MAIN: 40-04 JUNCTION BLVD. CORONA, NY 11368 PHONE: 718-713-0005 ● FAX: 718-713-0008 ● WWW.MARKSHHC.COM

LHCSA

PHYSICAL EXAMINATION REPORT

NAME:	Gender: ☐ Male ☐ Female	DOB:	SSN (Last 4):
ADDRESS:		PHONE:	

	COMMENTS		COMMENTS
HEAD		ABDOMINAL	
EYES		EXTREMITIES	
NECK		CARDIOVASCULAR	
THROAT		MUSCULOSKELETAL	
LUNGS		SKIN	
HEART		CENTRAL NERVOUS SYSTEM	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

RUBELLA LABS REQUIRED	DATE:	TITER: ☐ IMMUNE ☐ NON-IMMUNE	**MMR VACCINE DATES:** MMR 1:
RUBEOLA (MEASLES) LABS REQUIRED	DATE:	☐ IMMUNE ☐ NON-IMMUNE	MMR 2:
Drug Screen	DATE:	Results: ☐ Positive ☐ Negative	

PPD (Pre-employment requires 2-step)	1. Date Implanted: 2.	1. Date Read: 2.	RESULTS (MM): ☐ NEGATIVE ☐ POSITIVE ☐ NEGATIVE ☐ POSITIVE
QUANTIFERON LABS REQUIRED	DATE:	RESULTS: ☐ NEGATIVE ☐ POSITIVE	
CHEST X-RAY LABS REQUIRED	DATE:	RESULTS: ☐ WITHIN NORMAL LIMITS (WNL) ☐ ABNORMAL	

TUBERCULOSIS SCREENING QUESTIONNAIRE *(If yes, please provide additional testing)*

1. Productive Cough(Greater than 3 weeks)	YES ☐ NO ☐	5. Fever/Chills	YES ☐ NO ☐
2. Chest Pains	YES ☐ NO ☐	6. Fatigue/Tiredness for more than 3 weeks	YES ☐ NO ☐
3. Blood-Streaked Sputum	YES ☐ NO ☐	7. Night Sweats for no unknown reason	YES ☐ NO ☐
4. Unexplained Weight Loss	YES ☐ NO ☐	8. Persistent Shortness of Breath	YES ☐ NO ☐

BASELINE INDIVIDUAL TB RISK ASSESSMENT *(If yes, please provide additional testing)*

Temporary or permanent residence of >1 month in a country with a high TB rate	YES ☐ NO ☐
Current or planned immunosuppression	YES ☐ NO ☐
Close contact with someone who has had infections TB disease since the last TB test	YES ☐ NO ☐
Have you been treated with medication for TB?	YES ☐ NO ☐
Have you had a prior diagnosis of active TB/Latent TB infection or a positive skin test or positive blood test for TB?	YES ☐ NO ☐

INFLUENZA VACCINE

*** (If declined, sign Influenza Declination Form) ***

A Seasonal Influenza Vaccination Is Required Annually

INFLUENZAVACCINE ☐ PROVIDED ☐ DECLINED	Date:

☐ This individual is free from any health impairment (free of communicable diseases and free of habituation) that is a potential risk to the patient or other employee or which may Interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol. Based on the Health History provided, Physical Exam, and/or Lap test performed, to this person's physical and emotional condition, he/she will be permitted to work in the health care field

☐ This individual is able to work with the following limitations: _____

☐ This individual is not physically/mentally able to work (specify reason): _____

PHYSICAN SIGNATURE: _____ **DATE:** _____

PHYSICAN STAMP: _____ **LICENSE #:** _____

MARKS HOME CARE

TUBERCULOSIS SCREENING QUESTIONNAIRE

Name _____ **DOB:** _____

Please indicate if you are having any of the following symptoms for three to four weeks or longer (Questions 1-9 only):

1. **Productive Cough (greater than 3 weeks)** — **Yes** _____ **No** _____
2. **Blood-Streaked Sputum** — **Yes** _____ **No** _____
3. **Unexplained Weight Loss** — **Yes** _____ **No** _____
4. **Fever/Chills** — **Yes** _____ **No** _____
5. **Fatigue/Tiredness for more than 3 weeks** — **Yes** _____ **No** _____
6. **Night Sweats for no known reason** — **Yes** _____ **No** _____
7. **Persistent Shortness of Breath** — **Yes** _____ **No** _____
8. **Chest Pains** — **Yes** _____ **No** _____
9. **BCG Vaccine** — **Yes** _____ **No** _____
10. **Have you been in contact with anyone with active tuberculosis disease in the past year?** — **Yes** _____ **No** _____
11. **Do you have any medical condition, or are taking any medications, which suppress your immune system?** — **Yes** _____ **No** _____
12. **History of temporary or permanent residence (for>1 month) in a country with a high TB rate** — **Yes** _____ **No** _____
13. **Have you been treated with medication for TB?** — **Yes** _____ **No** _____
14. **Have you had a prior diagnosis of active TB or latent TB infection or a positive skin test or positive blood test for TB?** — **Yes** _____ **No** _____

If yes? Answer the following:

Positive TB skin test (PPD) or Positive Blood Test for TB Date: _____

Last Chest X-Ray Date: _____

Provider, please check off one of the two boxes:

☐ **NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.**

☐ **PRESENTS EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.** ***(Will require TB testing)***

_____ _____

Health Care Provider (M.D., N.P., P.A., R.N.) **License #**

_____

Date