# Pre-Employment Medical Form

## Demographic Information

| Name: | Address: | Title: |
|---|---|---|
| Date of Birth: | SSN: | Gender: M F |

## Vital Signs:

| Ht. | B/P | Temp |
|---|---|---|
| Wt. | Pulse | Resp |

## Physical Assessment Findings:

| System | WNL | COMMENTS |
|---|---|---|
| HEENT | ☐ | |
| Lungs | ☐ | |
| CNS | ☐ | |
| Cardiovascular | ☐ | |
| Musculoskeletal | ☐ | |
| Genitourinary | ☐ | |
| Abdomen | ☐ | |

## Tuberculosis:

| **PPD Dose #1** *(first step)* | **PPD Dose #2** *(within three weeks of 1st step)* |
|---|---|
| Date Implanted: ________ | Date Implanted: ________ |
| Date Read: ________ | Date Read: ________ |
| Result: ______mm | Result: ______mm |
| ☐ Negative | ☐ Negative |
| ☐ Positive | ☐ Positive |
| **QuantiFERON Test** *(if done instead of PPD)* | **Chest X-Ray** *(if positive PPD)* |
| Date Done: ________ | Date Done: ________ |
| Result: | Result: |
| ☐ Negative | ☐ Negative |
| ☐ Report Attached ***(required)*** | ☐ Report Attached ***(required)*** |

## TB Questionnaire:

| | | | |
|---|---|---|---|
| Unexplained Fever | Y / N | Fatigue/Tiredness for More than 3 Weeks | Y / N |
| Unexplained Chills for 1 or More Weeks | Y / N | Prolonged (Chronic) Cough Longer than 3 Weeks | Y / N |
| Unexplained Drenching Night Sweats | Y / N | Been treated for active and/or latent TB, positive skin test or positive blood test for TB | Y / N |
| Persistent Shortness of Breath | Y / N | Been treated with Medication for TB or for a Positive TB Test | Y / N |
| Unexplained Weight Loss | Y / N | Have you come in close contact with anyone who is/was sick with TB | Y / N |
| Persistent Chest Pain | Y / N | Current or planned immunosuppression including HIV, recipient of an organ transplant, chronic steroids | Y / N |
| Coughing up Blood | Y / N | History of temporary/permanent residence greater than 1 month in a country with high TB rate excluding U.S., Canada, Australia, New Zealand, northern/western Europe | Y / N |

## Immunization:

****LABORATORY TEST RESULTS MUST BE ACCOMPANIED BY LAB REPORTS****

| Rubella | Rubeola/Measles | Annual Flu Shot *(October - May)* |
|---|---|---|
| Titer Number: __________ ☐ Titer Report Attached *(required)* | Titer Number: __________ ☐ Titer Report Attached *(required)* | Name: ______________ Lot #: ______________ |
| ☐ Immune | ☐ Immune | Date Given: __________ Expiration Date: ______ |
| ☐ Not Immune | ☐ Not Immune | **OR** Declined: ☐ |
| Booster MMR Vaccine: __________ *(date given)* | 1st MMR Vaccine: __________ *(date given)* 2nd MMR Vaccine: __________ *(date given)* | |

## Physician's Acknowledgement:

***Please Select One of the Following:***

☐ This individual is free from any health impairment that is a potential risk to the patient or to another employee or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs, or substances which may alter the individual's behavior.

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

☐ The individual is **not** physically/mentally able to work ***(specify reason)***: ______________________________

**Physician's Name:** ______________________________

**Physician's Signature:** ______________________________

**Today's Date:** __________

**Physician's Stamp:** *(required)*

EHHC4321/6.22

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