Pre-Employment Medical Form

EDISON HOME HEALTH CARE
a Help at Home® company

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)* Date Implanted: _____ Date Read: _____ Result: _____mm ☐ Negative ☐ Positive	**PPD Dose #2** *(within three weeks of 1st step)* Date Implanted: _____ Date Read: _____ Result: _____mm ☐ Negative ☐ Positive
QuantiFERON Test *(if done instead of PPD)* Date Done: _____ Result: ☐ Negative ☐ Report Attached ***(required)***	**Chest X-Ray** *(if positive PPD)* Date Done: _____ Result: ☐ Negative ☐ 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
Titer Number: _____ ☐ Titer Report Attached ***(required)*** ☐ Immune ☐ Not Immune Booster MMR Vaccine: _____ *(date given)*	Titer Number: _____ ☐ Titer Report Attached ***(required)*** ☐ Immune ☐ Not Immune 1st MMR Vaccine: _____ *(date given)* 2nd MMR Vaccine: _____ *(date given)*	*(October - May)* Name: _____ Lot #: _____ Date Given: _____ Expiration Date: _____ **OR** Declined: ☐

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)*

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