Allpro Health Staffing **EMPLOYEE HEALTH ASSESSMENT**

☐ Pre-employment ☐ Annual Assessment ☐ Other: ________________

Name:	Marital Status: ☐ M ☐ S ☐ W ☐ D	Sex: ☐ M ☐ F
Address:	DOB:	Title:

Emergency Contact:	Relationship:
Emergency Address:	Telephone #:
INDICATE ILLNESS EXPERIENCED BY YOU OR FAMILY HISTORY	**HAVE YOU HAD ANY ILLNESS BELOW SINCE LAST ASSESSMENT**

CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			**MIGRAINE HEADACHES**		
KIDNEY DISEASE			**FAINTING OR DIZZINESS**		
HEART DISEASE			**WEIGHT GAIN/LOSS 15+LBS OR MORE**		
HIGH BLOOD PRESSURE			**CHANGE IN ENERGY LEVEL**		
ARTHRITIS			**FREQUENT COUGH**		
TUBERCULOSIS			**BLOOD IN SPUTUM**		
MENTAL ILLNESS			**SHORTNESS OF BREATH**		
EPILEPSY/CONVULSIONS			**CHEST PAIN/PRESSURE IN CHEST**		
CANCER			**SWELLING IN LEGS/FEET**		
TB SCREEN (HISTORY + PPD)	**YES**	**NO**	**PAIN IN CALF WHEN WALKING**		
CHEST PAIN			**CHANGE IN BOWEL HABITS**		
LINGERING COUGH			**BACK PAIN**		
LOSS OF ENERGY			**PAIN WHEN URINATING OR BLOOD IN URINE**		
UNEXPLAINED WEIGHT LOSS IN PAST YEAR			**HIGH BLOOD PRESSURE**		
BLOOD IN SPUTUM			**INFECTIOUS DISEASE**		
INCREASED SWEATING AT NIGHT			**INCREASED THIRST**		
			PERSISTANT SORES OR LUMPS		

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day?

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? ☐ Yes ☐ No If yes, specify:

Do you take prescription medications? ☐ Yes ☐ No If yes, list below:

Name of your physician?

Address: **Telephone #:**

I have read the above and declare that I have no injury, illness or ailment other than as specifically identified that may interfere with the performance of my job responsibilities. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: **Date:**

RN Reviewed Name: **Signature:** **Date:**

Allpro Health Staffing	**EMPLOYEE PHYSICAL EXAMINATION REPORT**

☐ **Pre-Employment Physical Assessment** ☐ **Annual Assessment** ☐ **Return to work/LOA** ☐ **Other:**

Name:	Marital Status: • M • S • W • D	Sex:• M • F
Address	SS #:	Title:

PHYSICAL EXAMINATION					
HEAD/ENT:					
EYES:					
NECK:					
BREASTS:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
COMMENTS:					
HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS

TEST	**DATE PERFORMED**	**RESULTS** PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		• NON-IMMUNE • IMMUNE **LAB VALUE:**	
MEASLES TITER		• NON-IMMUNE • IMMUNE **LAB VALUE:**	
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	

IMMUNIZATIONS:	**DATE**	**DATE**	**DATE**
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
MUMPS	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.

☐ **This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/he duties including the habituation or addiction to drugs or alcohol.**

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

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

Physician Signature:__________________________________ **Lic. No.** ______________ **Date:**______________