PHYSICAL / HEALTH EXAMINATION

Name: _____ Gender: ☐ Male ☐ Female

Allergies: _____

CLINICAL EVALUATION	NORMAL	ABNORMAL	Comments
Head / Face / Neck / Scalp			
Mouth / Throat			
Eyes – General			
Ears – General			
Lungs – Chest			
Heart			
Vascular System			
Abdomen – Viscera			
Upper Extremities			

Age: _____
Height: _____
Weight: _____
Pulse: _____
Temperature: _____
Blood Pressure: ____ /
Other Findings:

Does your physical examination of the applicant/employee reveal any physical limitation with respect:
Back / Spine: ☐ Yes ☐ No
Bending: ☐ Yes ☐ No
Lifting: ☐ Yes ☐ No

If you checked YES to any of the above, please describe the physical limitations: _____

_____

_____

PPD Test: ☐ Negative ☐ Positive ☐ Erythema _____ mm Induration _____ mm
A positive PPD must be followed by a chest x-ray unless contraindicated.

Chest X-Ray Results: _____
Any Treatment Recommended for Positive Chest X-Ray: _____
Comments: _____

Examining Physician's Statement:

☐ I certify that the employee is free from health conditions, which would interfere with his/her ability to perform assigned duties.
☐ I certify that the employee is free from signs or symptoms of infectious disease that would create hazards to patients.
☐ The following limitations have been found: _____

Physician's Full Name and Signature: _____

Physician's Address: _____

Telephone Number: _____ Date: _____