Agency: Gurwin Home Care Agency, Inc.

Name: ____ Date of Birth: __________________

Social Security #: ______________________________

Address: ____ telephone# ____________________

	Y	N		Y	N		Y	N		Y	N		Y	N
Seizure Disorder			Tuberculosis			High Blood Pressure			Swelling			Cancer		
Low Back Pain			Measles			Any Back Problems			Weakness/ paralysis			Syphillis		
Diabetes			Drug Use			Use of Depressants			Hepatitis			Gonorrhea		
Use of Stimulants			Allergies			Dizziness/ fainting			Use Narcotics			Use alcohol		

List any medical conditions that you are now or were previously being treated for by a physician. List any medications that you are taking or were previously taking that were prescribed by a physician.

X ____

Signature of Patient (*I authorize the release of this information to the organization listed above*)

Height: __________ Weight: __________ Blood Pressure: ________ / ________ Nose ________ Throat ________ Neck ________

Heart: __________ Lungs: __________ Back: __________ Abdomen: __________ Ears __________ Eyes ________

____Tuberculosis Test (Mantoux/PPD): Date implanted __________________ Arm (*circle*) L R

Date Read __________________ Result ______________ Negative *(0mm)* ______ Positive ________________ mm

_____ 2 Step PPD
Date implanted __________________ DateRead ______________ Result ________ Negative ______ Positive ________ mm

_____Chest X-Ray ________ Date __________ Result __________ NEGATIVE (*No Active Disease*) Positive __________________:

_____Rubella Titre: Date __________ Titre __________ Immune ________ Not Immune ________ Vaccination given ____________

_____Rubeola Titre: Date __________ Titre __________ Immune ________ Not Immune ________ Vaccination given ____________

_____Varicella Titre: Date __________ Titre __________ Immune ________ Not Immune ________ Vaccination given ____________

_____Mumps Titre: Date __________ Titre __________ Immune ________ Not Immune ________ Vaccination given ____________

Diptheria Tetanus (DT) Vaccination ______________________________ Given ______________________________

Hepatitis B Vaccination(s) ______ Date#1 __________________ Date#2 __________________ Date#3 __________________

Drug Screening Test: _____ Date ______________ Negative ______________ Positive(See Report) ____________________

I HAVE EXAMINED THE ABOVE NAMED INDIVIDUAL AND FIND THEM TO BE ABLE TO WORK: (CHECK ONE)

__________ Without Limitations __________ With Limitations(listed below) __________ May Not Work ____________

____

___The above named individual has a past history of a positive tuberculosis test and a negative chest X-ray. They are presently demonstrating NO signs or symptoms of active tuberculosis and does not require another X-ray and may work without limitations.

___Based upon this examination, the individual demonstrates no sign or symptoms of addiction to drugs or alcohol and may work.

Physicians Signature: ____ Date ______________________