FreedomCare
COMPASSION • INDEPENDENCE • CHOICE

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CAREGIVER PHYSICAL ASSESSMENT

NAME: _____ **PHONE** _____ **DATE OF BIRTH:** _____

I. PAST MEDICAL/PSYCHOLOGICAL HISTORY

Tuberculosis: ☐ No ☐ Yes
Diabetes: ☐ No ☐ Yes
Heart or Cardiovascular Disease: ☐ No ☐ Yes
Hypertension: ☐ No ☐ Yes
Cancer: ☐ No ☐ Yes
Kidney Disease: ☐ No ☐ Yes
Allergies (if yes, specify below): ☐ No ☐ Yes

_____

Epilepsy or seizure disorder: ☐ No ☐ Yes
Drug alcohol abuse or addiction: ☐ No ☐ Yes
Psychiatric or Behavioral Disorder: ☐ No ☐ Yes
Other: _____

Are you now taking medications? If so, for what?

_____

_____

II. MANDATORY IMMUNIZATIONS AND LAB TESTS (TO BE COMPLETED BY EXAMINER)

PPD (MANTOUX)

DATE GIVEN: _____
DATE READ: _____

RESULTS:

NEGATIVE: _____mm POSITIVE: _____mm

OR

WHOLE BLOOD ASSAY TEST FOR T.B.

DATE DRAWN: _____

RESULTS:

☐ NEGATIVE
☐ POSITIVE **Attach blood work**

IF POSITIVE, PROVIDE CHEST X-RAY RESULTS: DATE _____ RESULTS _____

RUBELLA

TITRE: _____ DATE: _____

RESULTS:

☐ IMMUNE ☐ NOT IMMUNE
RUBELLA VACCINE (IF NEEDED): _____

RUBEOLA (NOT NEEDED IF BORN BEFORE 1957)

TITRE: _____ DATE: _____

RESULTS:

☐ IMMUNE ☐ NOT IMMUNE
RUBEOLA VACCINE 1ST: _____ 2ND: _____

III. REVIEW OF SYSTEMS BY EXAMINER

HEAD/NECK: _____
EENT: _____
RESP: _____
CARDIOVASC: _____
ABD - GI: _____
GU: _____
MUSK - SKEL: _____
NEURO: _____
ENDOCRINE: _____
SKIN: _____
HEIGHT: _____
WEIGHT: _____

IV. MEDICAL EXAMINER:

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients and other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of his or her duties. I have questioned the patient and see nothing to contradict the patient's assertion that he or she is not habituated or addicted to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE _____ PHSYICIAN'S NAME (PRINT) _____

EXAM DATE _____ PHONE _____ ADDRESS _____

PLEASE USE PHYSICIAN'S STAMP!

Lab work for Rubeola and Rubella must always be attached, no matter the results!