



**QUALITY**  
HEALTHCARE, Inc.  
A LICENSED HOME CARE AGENCY

3512 QUENTIN RD. BROOKLYN, NY 11234  
P: (718) 338-8500 F: (718) 338-8838

**EMPLOYEE HEALTH EXAMINATION**

NAME: \_\_\_\_\_ RN/LPN/CNA/HHA

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ S.S. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_

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**TO BE FILLED OUT BY EMPLOYEE:**

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: no ( ) If yes, state: \_\_\_\_\_  
 Epilepsy or Seizure Disorder: no ( ) yes ( )  
 Drug/Alcohol Abuse or Addiction: no ( ) yes ( ) (attach lab slips)  
 Psychiatric or Behavioral Disorder: no ( ) yes ( )  
 Other: \_\_\_\_\_  
 Are you now taking medications? \_\_\_\_\_ If so, for what? \_\_\_\_\_

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**EXAMINER PLEASE COMPLETE:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

PPD Date: \_\_\_\_\_ Result: \_\_\_\_\_

Chest x-ray (if PPD is positive)  
Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Review of Systems:**

E, ENT \_\_\_\_\_  
 NECK \_\_\_\_\_  
 CHEST \_\_\_\_\_  
 LUNGS \_\_\_\_\_  
 HEART \_\_\_\_\_  
 ABDOMEN \_\_\_\_\_  
 EXTREMITIES \_\_\_\_\_  
 HEARING \_\_\_\_\_  
 VISION \_\_\_\_\_

**DOES EMPLOYEE CURRENTLY HAVE ANY OF THESE SYMPTOMS?**

**COMMENTS**

<b>Weakness</b>	<b>YES NO</b>	_____
<b>Fatigue</b>	<b>YES NO</b>	_____
<b>Lack of Appetite</b>	<b>YES NO</b>	_____
<b>Weight Loss</b>	<b>YES NO</b>	_____
<b>Low Grade Fever</b>	<b>YES NO</b>	_____
<b>Night Sweats</b>	<b>YES NO</b>	_____
<b>Shortness of Breath</b>	<b>YES NO</b>	_____
<b>Persistent cough</b>	<b>YES NO</b>	_____
<b>Blood streaked Sputum</b>	<b>YES NO</b>	_____
<b>Clear, Yellow or Dark Sputum</b>	<b>YES NO</b>	_____

**History of Infectious Diseases/Immunizations:**

Record of Immunizations:

**Diphtheria**    \_\_\_/\_\_\_/\_\_\_    Booster required every 10 years  
**Tetanus**     \_\_\_/\_\_\_/\_\_\_    Booster required every 10 years

**Rubella (German Measles):**

Titre    \_\_\_/\_\_\_/\_\_\_    Results: \_\_\_\_\_ **(attach lab slips)**  
If titre non-immune, Rubella vaccine to be given  
followed by titre in 3 months.    Vaccine \_\_\_/\_\_\_/\_\_\_

**Rubeola (Measles):**

**Born prior to 1/1/57 - no requirement.**

Born 1/1/57 or after:

Physician Diagnosed Measles    \_\_\_/\_\_\_/\_\_\_  
or

Titre    \_\_\_/\_\_\_/\_\_\_    Results: \_\_\_\_\_ **(attach lab slips)**  
or

2 doses of live measles vaccine (at least 30 days apart) followed by  
titre in 3 months: (1) \_\_\_/\_\_\_/\_\_\_    (2) \_\_\_/\_\_\_/\_\_\_

**Hepatitis B:**

I have received the following vaccination:

(1) \_\_\_/\_\_\_/\_\_\_    (2) \_\_\_/\_\_\_/\_\_\_    (3) \_\_\_/\_\_\_/\_\_\_

Antibodies test date: \_\_\_/\_\_\_/\_\_\_    Results: \_\_\_\_\_

I have declined the vaccination and submitted written declination. \_\_\_\_\_

Declination included: \_\_\_\_\_

**This employee is free from habituation or addiction to depressants, stimulants, narcotics, alcohol or other substances that may alter his behavior (see attached labs.) I have found no condition that appears to prevent him/her from performing the duties of the position applied for with the exception or the possible exception of the following:**

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Physician's Name

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Date

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MD SIGNATURE

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LICENSE #

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Physician's Phone #

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Physician's Address