PerfectChoice
STAFFING
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This Form Must Be Completed And Submitted Even If You Have Other Documentation.

PHYSICAL EXAMINATION REPORT

Patient Name: _____ Exam Date: _____

Height: _____ Weight: _____ B.P: _____ Temp: _____

Pulse: _____ Resp: _____ Eyes: _____ Ears: _____

Nose: _____ Throat: _____ Neck & Thyroid: _____Chest:_____

Heart: _____ Breasts: _____ Abdomen: _____ Back: _____

Muscles & Joints: _____ Skin: _____ Extremities: _____

Allergies: _____

Has Patient Taken Any Depressants, Narcotics, Barbiturates, Stimulants, Alcohol Or Other Drugs Or Substances Which May Alter Behavior? Yes _____ No _____
If Yes, Which Medication Or Drugs? _____

Immunization Summary

Rubella (German measles): Immunization Date: _____ Titer Results: _____
Rubeola (Measles): Immunization Date: _____ Titer Results: _____
Mumps: Immunization Date: _____ Titer Results: _____
Varicella Zoster (Chicken Pox): Immunization Date: _____ Titer Results: _____
Tetanus/Diphtheria: Date: _____
Hepatitis B: Yes _____ No _____ or Refused: _____ Date: _____ (See Waiver)
Vaccination Date: #1 _____ #2 _____ #3_____
Tuberculin Test - PPD: Date Administered: _____ Date Read: _____ Results: Negative / Positive _____ Mm
Chest X-Ray (If Positive): Date: _____ Results: Negative / Positive
2nd Step (If Needed): Date: _____

I Certify That I Have Examined The Above-Named Individual And Have Found His/Her Health To Be Satisfactory To Work In The Health Care Field.

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Physicians' Stamp: _____ **License #:** _____