Anchorhealth
home care services

EMPLOYEE HEALTH ASSESSMENT

Name: Direct Care ID:	Marital Status: ☐M ☐S ☐W ☐D	Sex:
Address:		Title:
Emergency Contact Name and Phone: _____		

INDICATE ANY ILLNESS EXPERIENCED BY YOU IN THE PAST:

CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS 15+lbs. OR MORE		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT/PERSISTANT COUGH		
TUBERCULOSIS			BLOOD IN SPUTUM		
MENTAL I LLNESS			SHORTNESS OF BREATH		
EPILEPSY/CONVULSIONS			CHEST PAIN/PRESSURE		
CANCER			SWELLING IN LEGS AND FEET		
PAIN IN CALF WHEN WALKING			CHANGE IN BOWEL HABITS		
BACK PAIN WHEN URINATING			INFECTIOUS DISEASE		
INCREASED THIRST			PERSISTANT SORES/LUMPS		

TB SCREEN

CONDITION	YES	NO	CONDITION	YES	NO
CHEST PAIN			INCREASED SWEATING AT NIGHT		
LINGERING COUGH			WEIGHT LOSS +15lbs IN 1 YEAR		

- **DO YOU SMOKE?** ☐ YES ☐ NO
- **DO YOU DRINK ALCOHOLIC BEVERAGES?** ☐ YES ☐ NO
- **DO YOU TAKE DEPRESSANT OR NARCOTIC DRUGS THAT ALTER YOU BEHAVIOR?** ☐ YES ☐ NO
- **DO YOU TAKE PRESCRIPTION MEDICATIONS?** ☐ YES ☐ NO

NAME OF YOUR PHYSICIAN: _____

PHYSICIAN PHONE #: _____

I HAVE READ THE ABOVE AND DECLARE THAT I HAVE HAD NO INJURY, ILLNESS OR OTHER AILMENT OTHER THAN IDENTIFIED. I CERTIFY THAT I AM NOT HABITUATED OR ADDICTED TO ANY STIMULANTS, DEPRESSANTS, DRUGS, ALCOHOL OR OTHER SUBSTANCES THAT MAY ALTER MY BEHAVIOR.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

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EMPLOYEE PHYSICAL EXAMINATION REPORT

Name: Direct Care ID:	Marital Status: ☐M ☐S ☐W ☐D	Sex:
Address:	SS#:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	CARDIOVASCULAR:
EYES:	MUSCULOSKELETAL:
NECK:	ABDOMEN:
BREASTS:	GENITOURINARY:
LUNGS:	CENTRAL NERVOUS SYSTEM:
HEAD/ENT:	CARDIOVASCULAR:
COMMENTS:	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

TEST RESULTS: MUST INCLUDE LABORATORY REPORTS

PPD	DATE IMPLANTED:	DATE READ:	RESULTS (mmxmm):
TB QUANTIFERON GOLD	DATE:	◀ MUST INCLUDE LABWORK REPORT	
CHEST X-RAY	DATE:	◀ MUST INCLUDE LABWORK REPORT	
RUBELLA TITER	DATE:	◀ MUST INCLUDE LABWORK REPORT	
RUBEOLA TITER	DATE:	◀ MUST INCLUDE LABWORK REPORT	
DRUG SCREEN	DATE:	◀ MUST INCLUDE LABWORK REPORT	

VACCINATIONS

RUBELLA	DATE:			
RUBEOLA/MEASLES: **TWO DOSES REQUIRED** **Only if DOB is on or after 1/1/1957	DATE:	DATE:		
INFLUENZA	DATE:	MANUFACTURER:	LOT NUMBER:	EXP. DATE:
	VOL (ml):	ROUTE:	SITE:	

TUBERCULOSIS (TB) SCREEN

According to the Center for Disease Control & Prevention, a chest x-ray needs to be completed for any person with a positive PPD test or pulmonary symptoms suggestive of TB. The chest x-ray must be repeated every ten (10) years and an annual TB screen must be completed until the new chest x-ray is performed.

Does the patient have any of the following symptoms?

	YES	NO		YES	NO
Chronic Cough			**Hoarseness**		
Night Sweat			**Wheezing**		
Unexplained Weight Loss			**Shortness of Breath**		
Hemoptysis (coughing up blood)			**Chest Pains**		

☐ **This individual is free from any health impairment that is a potential risk to the patient or other employee o which may interfere with the performance of his/her duties including habituation or addiction to drugs or alcohol.** ☐ **This individual is able to work with following limitations:** ☐ **This individual is not physically/mentally able to work. *(specify reason):***	**DOCTORS STAMP**

Physician Signature: _____ **Lic. No.** _____ **Date:** _____