Physical Examination

TOWNE NURSING STAFF, INC.

Name _____ Date of exam ___/___/ ___

Address _____

City _____ State _____ Zip _____

Date of Birth _____/_____/ _____ Tel _____

EXAMINATION: (check *each* item if normal, otherwise explain)

BP: _____/_____ Temp: _____ Pulse:_____ Respiration:_____ Weight: _____ Height:_____

1. General ☐ _____
2. Skin ☐ _____
3. Head ☐ _____
4. Eyes ☐ _____
5. Ears ☐ _____
6. Nose ☐ _____
7. Mouth/Throat ☐ _____
8. Neck ☐ _____
9. Thorax/Lung ☐ _____
10. Cardiac ☐ _____
11. Abdomen ☐ _____
12. Back ☐ _____
13. Extremities ☐ _____
14. Musculoskeletal ☐ _____
15. Neurological ☐ _____
16. Psychiatric ☐ _____

DIAGNOSIS AND ASSESSMENT OF MEDICAL PROBLEMS:

☐ No medical problems

☐ Ongoing medical problems (explain) _____

_____

_____

LIMITATIONS / RECOMMENDATIONS:

☐ No limitations

☐ Limitation(s) *explain:* _____

_____

HISTORY:

- **Habituation / Addiction**

☐ Alcohol ☐ Stimulants

☐ Depressants ☐ Narcotics ☐ Other _____

If any, please explain _____

_____

- **Illness/Injury**

Please indicate any past or present condition that would result in physical, mental or behavioral limitations in normal functioning _____

Physical Examination

Towne Nursing Staff, Inc.

Name: _____ Date of exam: _____

MANDATORY IMMUNIZATION / TEST:

☐ DIPHTHERIA / TETANUS- booster required once every ten years

Date of last immunization ____/____/____

☐ TUBERCULOSIS: PPD (Mantoux) Skin test only (Tine test unacceptable)

Previous BCG vaccination **does not** negate the need for PPD testing.

PPD- Date given ____/____/____

Manufacturer_____ Dose_____ Lot # _____

Date read ____/____/____ Result _____mm

If PPD Positive: Chest x-ray is required; **Copy of x-ray report MUST be included.**

Date ____/____/____ Result _____ (enclose copy of report)

To be completed by health care provider

Instructions to the health care provider: All dates must include month, day, and year. Please mark (x) the appropriate boxes

		month	day	year
MMR (measles, mumps, rubella), if given as a combined dose instead of individual immunizations				
☐ Dose 1	Immunized after 1 year of age and after 1972			
☐ Dose 2	Immunized after 1972 and at 5 years of age or older			
or-				
☐ **Measles** Dose 1	Immunized on or after Jan1, 68 or after first birthday **-AND-**			
☐ **Measles** Dose 2	Immunized at least 28-30 days after first dose			
☐ **Rubella**	Immunized with vaccine on or after 1 year of age			
☐ **Mumps**	Immunized with live vaccine after 1 year of age and after 1969			
or-				
Titre (blood test) showing positive immunity ***(Dated lab results MUST be attached)***				
☐ **Measles** – titre level _____				
☐ **Rubella** – titre level _____				
☐ **Mumps** – titre level _____				

After examination as required and to the best of my knowledge, I have determined that this individual is free from any health impairment that is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior or judgment.

Examining physician (print): _____

Signature of examining physician: _____

Address: _____

_____

Telephone: (_____) _____ Date _____