BEST CHOICE HOME HEALTH CARE
A Member of the Beth Abraham Family of Health Services

596 Prospect Place, Brooklyn, NY 11238 (718)362-1440
2275 Olinville Avenue, Bronx, NY 10467 (718) 944-2255

PRE-EMPLOYMENT PHYSICAL

Name: _____ Male ☐ Female ☐

Address: _____ Date of Birth: _____

Telephone#: _____ SS# (Last 4 digits): _____

Medical Practitioner: Please complete the following:

Height: _____ Weight: _____ BP: _____ T.P.R _____

1. Immunizations and Lab Tests:

* PPD # 1(Mantoux) Pos ☐ Neg ☐ Date Implanted: _____ Date Read: _____

* PPD # 2: (Mantoux) Pos ☐ Neg ☐ Date Implanted: _____ Date Read: _____

Chest X-ray: (If PPD is positive) Pos ☐ Neg ☐ Date: _____
(Attach lab report)

* Rubella Pos ☐ Neg ☐ Titer: _____ Date: _____

* Rubeola (if born after 12/31/56) Pos ☐ Neg ☐ Titer: _____ Date: _____

* MMR Vaccine (alternate for Rubella & Rubeola) Date: _____ Date: _____

* Varicella Vaccine Date: _____

* Hepatitis B Vaccine (optional) #1 Date: _____ #2 Date: _____ #3 Date: _____Titer: _____

Medical Exemption from Influenza Vaccine:
Yes ☐ (complete attached exemption form) No ☐ (complete information below)

* Seasonal Influenza Vaccine (for applications from Sept. to Mar.) Date: _____

Type of vaccine: _____ Dose: _____
Manufacturer & Lot #: _____ Site of Administration: _____

Person administering the vaccine:
Name: _____
Last Name First Name
Signature: _____ Title: _____
Reactions (if applicable): _____

2. Review of Systems:

Cardiovascular	_____	Muscular	_____
Digestive	_____	Nervous	_____
Endocrine	_____	Reproductive	_____
Excretory	_____	Respiratory	_____
Immune	_____	Skeletal	_____

Present Medication(s): Yes☐ No ☐ (If yes, attach list of medications, dosages, and purpose)

Name: _____ SS# (Last 4 digits): _____

2. Past Medical History	YES	NO
Any serious problems, surgery	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐
Mental/Behavioral Disorder	☐	☐
Cardiovascular Disease	☐	☐
Hypertension/Hypotension	☐	☐
Asthma	☐	☐
Epilepsy/Seizure Disorder	☐	☐
Cancer	☐	☐
Kidney Disease	☐	☐
Drug/Alcohol Abuse	☐	☐
Allergies	☐	☐

Other _____

3. Tuberculosis (TB) Questionnaire/Screening	YES	NO
Exposure to TB at Work/Home	☐	☐
Positive Chest X-Ray	☐	☐
Unintended Weight Change (+/- 10 lbs)	☐	☐
Persistent Cough	☐	☐
Conversion to Positive PPD	☐	☐
Low Grade Fever	☐	☐
Unexplained fatigue	☐	☐
Blood Streaked Sputum	☐	☐
Active TB	☐	☐
Night Sweats	☐	☐
Loss Appetite	☐	☐
Clear, Yellow or Dark Sputum	☐	☐

I certify that I have examined the above-named individual and found him/her to be free of any addiction/ habituation to depressants, stimulants, narcotics, illegal drugs, or alcoholic substances. Yes ☐ No ☐

I certify that I have examined the above-named individual and found him/her to be:

[ ] Fully Employable – No limitations

[ ] Employable – Suggest Follow Up and/or completion of: _____

[ ] Not Currently Employable – Recommend Additional Testing /Treatment and/or Follow Up as soon as possible for: _____

Medical Practitioner's Signature _____ Date: _____

Address: _____ Phone #: _____

Title: _____ **Office Stamp:**

License #: _____

Please note:

- **Physical is not acceptable without Medical Practitioner's stamp; which includes practitioner's name, address, phone # and license #. Form must be stamped and signed.**
- **If applicable, a copy of Chest X-Ray Report must be attached**
- **Toxicology Screening will be scheduled by Best Choice Home Health Care.**