Physical Assessment Form for Healthcare Workers

Personal Information:

Full Name: _____

Date of Birth: _____

Gender: _____

Contact Number: _____

Emergency Contact: _____

Work Information:

Job Title: _____

Department: _____

Date of Assessment: _____

Supervisor's Name: _____

Medical History:

Known Medical Conditions: _____

Current Medications: _____

Allergies: _____

Vaccination Status: _____

Physical Examination:

Height: _____

Weight: _____

Blood Pressure: _____

Heart Rate: _____

Vision Test: _____

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Assessment Summary:

Observations: _____

Recommendations: _____

Assessed By: _____

Date: _____

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