CHOICE
Home Health Services

HEALTH HISTORY AND PHYSICAL EXAMINATION

Employee Name/Title: _____

Social Security #: _____ Date of Employment: _____

HISTORY (To be filled out by Applicant/Employee)

Have you had or do you have any of the following conditions:

Allergies	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Fainting or Dizziness	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Headache (frequent)	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Hearing Disability	☐ Yes	☐ No	Visual Disability	☐ Yes	☐ No
Heart Trouble	☐ Yes	☐ No	Other	☐ Yes	☐ No

PHYSICAL EXAMINATION (To be filled out by physician)

Height: _____ Weight: _____ Blood Pressure: ____ / ____ Pulse: _____

PPD Test: Date Administered _____ Indicate: ☐ Positive ☐ Negative

Chest X-Ray (if indicated): Date Administered _____ Indicate: ☐ Positive ☐ Negative

Comments: _____

_____

_____

_____

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone Number: _____

I certify that the applicant is free from health conditions, which would interfere in his/her ability to perform his/her assigned duties, and is free from symptoms of infectious disease.

_____ _____

Physician's Signature Date of Examination