Mobile Health

Mobile Health
Pre-Employment Physical Examination Form

EMPLOYEE NAME: _____ **DATE OF BIRTH**:_____

Health Screen (Medical History)

Past Medical Illness: ▫ None Reported

▫ Measles	▫ Rubella	▫Varicella (Chicken Pox)
▫ Mumps	▫ Tuberculosis	

Past Medical History: ▫ None Reported

▫ Anemia	▫ Epilepsy	▫ Hyperthyroid	▫ Neuropathy
▫ Asthma	▫ GERD/GI Disorder	▫ Hypothyroid	▫ Sickle Cell Trait or Disease
▫ Anxiety	▫ Glaucoma	▫ Kidney Disease	▫ Stroke/CVA/TIA
▫ Cancer	▫ Heart Disease	▫ Liver Disease	▫ Injury: non-work
▫ Cataracts	▫ Headaches	▫ Motor Vehicle Accident	▫ Injury: work
▫ COPD or Lung Disease	▫ Hepatitis___ (A, B, C?)	▫ Musculoskeletal disorder	▫ Other: _____
▫ Diabetes Type I		▫ Neck or lower back pain	_____
▫ Diabetes Type II	▫ High Blood Pressure		_____
	▫ Hypercholesterolemia (Lipid Disorder)		

Past Surgical History: ▫ None Reported

▫ Appendectomy	▫ Cholecystectomy	▫ Liposuction	▫ Salpingectomy
▫ Breast reduction	▫ Hemorrhoidectomy	▫ Lumpectomy	▫ Tonsillectomy
▫ Cataract removal	▫ Hysterectomy	▫ Mastectomy	▫ Thyroidectomy
▫ C-Section	▫ Laminectomy	▫ Ovarian cystectomy	▫ Tubal Ligation

Date of last surgery: Other Surgical Notes:

Medications: ▫ None Reported ▫ Use Reported:

If Use Reported, list all medications: _____ _____ _____ _____ _____ _____

Allergies:

▫ Seasonal	▫ Penicillin	▫ Latex	▫ Smoke	▫ Vinyl
▫ Nitrate	▫ Animal/Pet Dander		▫ Other/Drug: _____	

Please list known allergic reactions: _____

Social History:

Tobacco Use:	▫ Denies present tobacco use	▫ Smoke several cigarettes per day	▫ Smokes >1 pack/day	▫ Social Smoker
Length of Tobacco Use:	▫ N/A	▫ 1-5 years	▫ 6-10 years	▫ >10 years
Alcohol Use	▫ Denies use	▫ Consumes alcohol socially	▫ Consumes alcohol occasionally	▫ Consumes alcohol on a daily basis
Narcotic/Stimulant Use:	▫ Denies use	▫ Presently using prescribed narcotics	▫ Presently using prescribed stimulants	

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Test/Vaccination	Date	Immune	Non-Immune		Date	Negative	Positive
Rubella		☐	☐	Quantiferon Test (QFT)		☐	☐
Rubeola (Measles)		☐	☐	PPD (Step 1)		☐	☐
MMR Vaccine (1st Dose)				PPD (Step 2)		☐	☐
MMR Vaccine (2nd Dose)				If PPD/QFT positive - Chest Xray (**must state 'negative for active TB'*)		**** must attach report**	
**** All labs (vaccinations as required) MUST be performed and reports MUST be attached**							

Tuberculosis Risk Assessment Screening

☐ Yes	☐ No	Productive cough for more than 3 weeks	☐ Yes	☐ No	Fever, chills or drenching night sweats for no known reason
☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No	Persistent shortness of breath
☐ Yes	☐ No	Unexplained weight loss	☐ Yes	☐ No	Unexplained fatigue for more that 3 weeks
☐ Yes	☐ No	Chest pain			
☐ Yes	☐ No	Temporary or permanent residence (for >1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)	☐ Yes	☐ No	Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone>15mg/day for >1 month) or other immunosuppressive medication
☐ Yes	☐ No	Have you had close contact with someone who has TB	☐ Yes	☐ No	Do you have documentation of prior TB tests, either a tuberculin skin test (TST) or an interferon-gamma release assay (IGRA) blood test and results
☐ Yes	☐ No	Do you have a history of TB, LTBI and treatment			

PHYSICAL EXAM
Normal (NL) Abnormal (AB)

Vitals: B/P:_____ **Pulse**:_____ **Resp**: _____

	NL	AB	Comment		NL	AB	Comment
General Appearance				Cardiac			
Skin				Abdomen			
Head, Eyes, Ears, Nose and Mouth				Respiratory			
Neck				Neurologic			
Musculoskeletal / Gait				Psychiatric			
Genito-Urinary (including hernias)				Other Body systems			

☐ This individual is free from health impairments which are of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior

☐ This individual is able to work with the following limitations

_____

☐ This individual is not physically/mentally able to work (specify reason):_____

Clinician Signature: _____ **Date**: _____

Printed Name: _____ **License Number & State**: _____

__Please provide your stamp**__**