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

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)

	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**: _____

<u>Please provide your stamp**</u>**