

# Health Examination Form

Date of Exam: \_\_\_/\_\_\_/\_\_\_

[ ] Male [ ] Female

Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_ -- \_\_\_ -- \_\_\_

Weight: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_ -- \_\_\_

Height: \_\_\_\_\_

Medical History: \_\_\_\_\_  
 \_\_\_\_\_

**Habitation/Addiction:**

Yes [ ] No [ ]

**Health Status:**

Skin: \_\_\_\_\_

Heart: \_\_\_\_\_

Head and Neck: \_\_\_\_\_

Lungs: \_\_\_\_\_

Eyes: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Ears: \_\_\_\_\_

Back: \_\_\_\_\_

Nose: \_\_\_\_\_

Extremities: \_\_\_\_\_

Oral Cavity: \_\_\_\_\_

Reflexes: \_\_\_\_\_

Chest: \_\_\_\_\_

**Significant Findings:**

\_\_\_\_\_

	Date Issued	Date Read	Results
• PPD (Mantoux) required annually	_____	_____	_____
• Booster PPD	_____	_____	_____
• Chest X- Ray (if positive PPD)	_____	_____	_____

**Immunization History:**

• Rubeola Vaccine (German Measles)	_____	Immune?	Yes	or	No
• Rubella Vaccine (if born after 1957)	_____	Immune?	Yes	or	No
• Mumps Vaccine	_____	Immune?	Yes	or	No
• Diphtheria Vaccine	_____	Immune?	Yes	or	No
• Tetanus Vaccine	_____	Immune?	Yes	or	No
• Varicella Vaccine	_____	Immune?	Yes	or	No
• Hepatitis B: Vaccination Dates	_____	_____	_____	_____	_____

Is individual free from communicable disease? : Yes [ ] No [ ]

Is individual free from health impairments that would present a risk to the residents of the facility, which cannot be reasonably accommodated? : Yes [ ] No [ ]

If no to any of the above, please specify: \_\_\_\_\_  
 \_\_\_\_\_

**MD Name:** \_\_\_\_\_  
**MD Signature:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**Date:** \_\_\_\_\_