WHITE GLOVE
COMMUNITY CARE
A Legacy of Quality Homecare

Annual Physical Examination Report

Name_____ Date of Birth _____

Address_____ Last 4 Social Security # xxx-xx-_____

Date of Physical _____ **HEIGHT**_____ **WEIGHT**_____ **B/P**_____

Laboratory Results ***Please attach all labs***

Influenza Vaccine Immunization Date_____ Lot#_____

Drug Screening (LABS MUST BE ATTACHED) Date:_____ Results: _____

COVID-19 1st Dose _____ 2nd Dose _____ Booster _____

Health Questionnaire for Tuberculosis

Treated with Tuberculosis Medication? Yes _ No _

Medication(s) Used: _____

Have you ever received a BCG (Tuberculosis Vaccination)?
Yes No_

Have you been exposed to an isolated case of TB this year?
Yes _ No _

Do you have any of the following?

Chronic cough (3 weeks or more)	Yes _	No
Production of sputum	Yes _	No
Blood-streaked sputum	Yes _	No
Persistent night sweats	Yes _	No
Involuntary weight loss	Yes _	No
Chronic Fatigue/Tiredness	Yes _	No

Fever	Yes _	No _
Shortness of breath	Yes _	No _
Any serious illness	Yes _	No _

If you answered "yes" to any of the above, please explain:

_____

Are you under medical treatment for any condition at this time?

Yes No _

If you answered "yes", please explain:

_____

_____

Have you had any of the following? This section must be complete (If you answer yes, follow up with medical provider is needed)

Yes	No		Yes	No		Yes	No		Comments:
[]	[]	Chest pain	[ ]	[ ]	Shortness of breath	[ ]	[ ]	Ankle swelling	
[ ]	[]	Dizziness	[ ]	[]	Frequent headaches	[ ]	[]	Unexplained stomach pain	_____
[ ]	[]	Ringing in your ears	[ ]	[]	Double vision	[ ]	[]	Change in urination	_____
[ ]	[]	Change in your voice	[ ]	[]	Chronic cough	[ ]	[]	Night sweats	_____
[ ]	[]	Sore that does not heal	[ ]	[]	Drastic change in weight	[ ]	[]	GYN/GU problems	
[ ]	[]	Loss/gain of 20lbs/more	[ ]	[]	Recent change in your bowels	[ ]	[]	Blood in stool	
[ ]	[]	Back pain	[ ]	[]	Back injury-hospitalized	[ ]	[]	Change in sleep patterns	
[ ]	[]	Surgery in the past 5 years	[ ]	[]	Hypertension	[ ]	[]	Unexplained fatigue	_____
[ ]	[]	Diabetes	[ ]	[]	Allergies	[ ]	[]	Seizure condition	

This individual is free from any health impairments which would place patients, their families or fellow employees at risk or which would interfere with the performance of his/her job duties. These factors include, but are not limited to, habituations or active addiction to alcohol, depressants, stimulants, narcotics or other substances that may alter your behavior.
I certify that I have examined the above names individual and have found his/her health to be satisfactory to work in the health care field.

(Please include medical provider signature, stamp and date)

Medical Provider Signature:_____ Date: _____

Medical Provider Name:_____ License # _____

Address:_____ Phone#_____