UNIQUEAID
Tailoring Home Health Care for Your Unique Situation.

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PHYSICAL EXAMINATION RECORD

Employee Name:_____

Employee Address:_____

Phone Number:(_____) _____ - _____ DOB:_____/_____/_____

Do not write below. Doctor should fill out information only.

Height:_____ Weight:_____ Blood Pressure:_____/_____

Please indicate Yes or No	Y	N		Y	N		Y	N
Operation	❒	❒	Back Injury	❒	❒	Tuberculosis	❒	❒
Sinus	❒	❒	Hypertension	❒	❒	Epilepsy	❒	❒
Diabetes	❒	❒	Asthma	❒	❒	Stomach Trouble	❒	❒
Heart Trouble	❒	❒	Mental Problem	❒	❒	Jaundice	❒	❒
Head Injury	❒	❒	Skin Rashes	❒	❒	Hernia	❒	❒
Scars	❒	❒	Fractures	❒	❒		❒	❒

Please indicate any problems with the following:			
Ears		Heart	
Eyes		Abdomen	
Teeth		Menstrual History	
Lungs		Others	

1. Is there habituation or alcohol, depressants, stimulants, narcotics or other substances that may affect this patient's behavior?	❒ Yes	❒ No
2. Do you feel this patient is physically able to assume the duties of a Home Health Aide or Nurse?	❒ Yes	❒ No
3. Has this patient received the Hepatitis B vaccination? If yes, date:_____	❒ Yes	❒ Declined

Tuberculosis/PPD Test (if required)

2 Step PPD	Date Given				Date Checked
1st Step	_____/_____/_____	Positive	❒	Negative ❒	_____/_____/_____
2nd Step	_____/_____/_____	Positive	❒	Negative ❒	_____/_____/_____

Alternative PPD Assessment

X-Ray	_____/_____/_____	PLEASE ATTACH COPY OF RESULTS

Comments:_____

Examining Physician:_____ License Number:_____

Address:_____

Signature:_____ Date:_____

Staff RN Review:_____ Date:_____