HEALTH SCREENING

Name: _____ D.O.B._____

Present Illness/Complaint/Disabilities: _____

_____

Allergies: _____

Medicine currently prescribed and reason: _____

_____

Has client been exposed to any communicable disease: Yes____ No____

If "yes" specify: _____

Past history of chronic or major illness: _____

_____

Operations: _____

Hospitalizations: _____

Immunizations: Tetanus _____Polio _____Measles _____

Mumps _____ Rubella _____ Other _____

Respirations _____ Temperature _____

General appearance (include signs of drug abuse)

Nutrition:_____

Head: _____

Ears: _____Hearing: R._____ L._____

Eyes: _____Vision: w/o glasses R_____ L _____with glasses: R _____L _____

Nose: _____ Throat: _____ Mouth/Teeth: _____

Neck/Thyroid: _____ Chest:_____ Breast:_____

Cardiac: _____ Abdomen:_____ Genitalia:_____

Hernia: _____ Muscle/Skeletal: _____

Neurological:_____ Skin: _____

Required Lab Work

C.B.C. & Differential: _____

V.D.R.L._____ Urinalysis:_____

Vaginal V D.R.L. _____ Pregnancy Test _____

Liver Function Tests: _____

Hepatitis-A _____ Hepatitis-B _____ Hepatitis-C _____

T.B. Skin Test _____Chest X-Ray (if T.B. pos.) _____

H.I.V. Antibody: _____

General Comments, Assessments, or recommendations on above: _____

_____

_____
Signature of examining Physician

_____
Print Name of Examining Physician

_____
Address

_____

_____
Phone Number

_____
Date of Exam