TRANSITIONS

PHYSICAL EXAMINATION FORM

NAME:_____ **DATE:**_____

D.O.B:_____ **HT:**_____ **WT:**____ **BP:**_____

Please check any of the conditions that apply:

Patient to answer the following questions:	**Yes**	**No**
1. Do you have diabetes mellitus?	☐	☐
2. Do you have high blood pressure?	☐	☐
3. Do you have asthma or other respiratory disorder?	☐	☐
4. Do you have a back injury?	☐	☐
5. Do you have any physical limitations?	☐	☐
6. Do you have any addictions to controlled substances?	☐	☐
7. Are you on any prescribed or controlled medications?	☐	☐

Please explain any of the questions you checked with a Yes._____

_____

I confirm that above answers are correct:_____ ***(patient signature)***

_____

RUBELLA TITER: (attach lab report) **Date:**_____ **MUMPS Titer:** (attached lab report) **Date:**_____

RUBEOLA TITER: (attach lab report) **Date:**_____ **HEPATITIS B Titer:** (attach lab report) **Date:**_____

DECLINE HEP B Vaccination: Date:_____

VARICELLA TITER: (attach lab report) **Date:**_____ **INFLU ENZA** (during flu season) **Date:**_____

TUBERCULIN (MANTOUX) PPD: Date Placed:_____ **Location:**_____ **Lot#:**_____

Placed By:_____ ***(Title)***

RESULTS: _____ **/mm** **DATE:** _____ **Read By:**_____ ***(Title)***

CHEST X-RAY RESULTS:_____ **Date:**_____

(only required following positive PPD)

COMMENTS: _____

_____

I HAVE EXAMINED THE ABOVE NAMES INDIVIDUAL AND HAVE FOUND HIS/HER HEALTH TO BE ADEQUATE FOR SCHOOL OR WORK IN THE HEALTH CARE FIELD.

SIGNATURE OF PHYSICIAN:_____ **Date:**_____

ADDRESS:_____ **LICENSE#:**_____ **TELEPHONE #:**_____

PLEASE AFFIX PHYSICIAN'S STAMP HERE:

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