ESHYFT

PHYSICIAN CLINICAL EXAMINATION

Name ______________________ Date of Birth____/___/____ Date of exam ___/___/____

Address______________________________City_______________ State____ Zip_______

EXAMINATION: (check *each* item if normal, otherwise explain)

BP: _______/_______Temp: ______Pulse: _______Respiration:_________ Weight: ________ Height:__________

1. General ☐ ____________________
2. Skin ☐ ____________________
3. Head ☐ ____________________
4. Eyes ☐ ____________________
5. Ears ☐ ____________________
6. Nose ☐ ____________________
7. Mouth/Throat ☐ ____________________
8. Neck ☐ ____________________
9. Thorax/Lung ☐ ____________________
10. Cardiac ☐ ____________________
11. Abdomen ☐ ____________________
12. Back ☐ ____________________
13. Extremities ☐ ____________________
14. Musculoskeletal ☐ ____________________
15. Neurological ☐ ____________________
16. Psychiatric ☐ ____________________

DIAGNOSIS AND ASSESSMENT OF MEDICAL PROBLEMS:

☐ No medical problems ☐ Ongoing medical problems (explain)______________________________

LIMITATIONS / RECOMMENDATIONS:

☐ No limitations ☐ Limitation(s) *explain:*______________________________

MANDATORY IMMUNIZATION / TEST:

☐ TUBERCULOSIS: PPD (Mantoux) Skin test only (Tine test unacceptable. Previous BCG vaccination **does not** negate the need for PPD testing.)

PPD #1 Date given ____/____/____ **PPD** Date read ____/____/____ Result _____mm

PPD #2 Date given ____/____/____ **PPD** Date read ____/____/____ Result _____mm

If PPD Positive: Chest x-ray is required; Copy of x-ray report MUST be included.

Date ____/____/____ Result ______________ (enclose copy of report)

Instructions to the health care provider: All dates must include month, day, and year. Please mark (x) the appropriate boxes

	month	day	year
MMR (measles, mumps, rubella), if given as a combined dose instead of individual immunizations			
☐ Dose 1 Immunized after 1 year of age and after 1972			
☐ Dose 2 Immunized after 1972 and at 5 years of age or older			
or- ☐ **Measles Dose 1** Immunized on or after Jan1, 68 or after first birthday **-AND-**			
☐ **Measles Dose 2** Immunized at least 28-30 days after first dose			
☐ **Rubella** Immunized with vaccine on or after 1 year of age			
☐ **Mumps** Immunized with live vaccine after 1 year of age and after 1969			
or- **Titre** (blood test) showing positive immunity ***(Dated lab results MUST be attached)***			
☐ **Measles** – titre level ________________			
☐ **Rubella** – titre level ________________			
☐ **Mumps** – titre level ________________			

After examination as required and to the best of my knowledge, I have determined that this individual is free from any health impairment that is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior or judgment.

Examining physician (print):______________________________

Signature of examining physician: ______________________________

Telephone: (__________) ______________________________ Date ______________________