LINDA HEALTHCARE CORPORATION ANNUAL PHYSICAL

CONTRACTOR:_____ DATE:_____

ANNUAL HEATH STATEMENT (TO BE COMPLETED BY CONTRACTOR):

NAME CHANGE SINCE LAST PHYSICAL YES NO

ADDRESS:_____

TELEPHONE #:_____

EMERGENCY CONTACT:_____

LIST ANY ALLERGIES OR SENSITIVITIES TO DRUGS, SOAP, GLOVES, ETC:

_____

LIST ALL MEDICATIONS TAKEN REGULARLY:_____

LIST ANY HEALTH CHANGES SINCE LAST PHYSICAL:

_____

UNEXPLAINED WEIGHT LOSS	YES NO
UNEXPLAINED LOSS OF APPETITE	YES NO
PRODUCTIVE COUGH (FOR MORE THAN 3 WEEKS)	YES NO
BLOODY SPUTUM	YES NO
NIGHT SWEATS (NOT RELATED TO MENOPAUSE)	YES NO
CHRONIC FATIGUE	YES NO
SWOLLEN GLANDS (TYPICALLY IN NECK)	YES NO
CHANGE IN DENTAL STRUCTURE	YES NO
SURGERY IN THE PAST YEAR	YES NO
PHYSICAL LIMITATIONS	YES NO
ANY COMMUNICABLE DISEASES	YES NO
ANY SERIOUS ILLNESS (EPILEPSY, DIABETES, ETC)	YES NO
LOSS OF SIGHT OR UNCORRECTED VISION	YES NO
CARDIOVASCULAR DISORDERS	YES NO
PSYCHONEUROTIC DISABILITY FOLLOWING TREATMENT	YES NO
PERMANENT INJURY WHICH CONSTITUTES 20% IMPAIRMENT	YES NO

PLEASE EXPLAIN ANY "YES" ANSWERS IN THE ABOVE SECTION:

_____

_____

I CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE CONTRACTOR'S **SIGNATURE:**_____

ANNUAL HEALTH STATEMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)

B/P_____ P_____ SAO2_____ HT _____ WT_____ HGB_____

TB SCREENING:

PPD: GIVEN BY:_____ DATE:_____

SITE:_____ INJECTION LOT#_____ & EXP:_____

PPD MUST BE READ BY A PHYSICIAN OR RN 48 TO 72 HOURS AFTER ADMINISTRATION
RESULTS:_____ DATE READ:_____ NEXT DUE:_____

_____
SIGNATURE AND TITLE OF PERSON READING THE TEST

CHEST X-RAY: DONE BY:_____. DATE:_____

RESULTS:_____ DATE READ:_____ NEXT DUE:_____

_____
SIGNATURE AND TITLE OF PERSON READING THE TEST

HEPATITIS SCREENING:

HEPATITIS B SURFACE ANTIBODY POSITIVE DATE: _____

_____
SIGNATURE AND TITLE OF PERSON READING THE TEST

IF HEPATITIS B SURFACE ANTIBODY IS NEGATIVE, RECOMBIAX IS REQUIRED

INITIAL INJECTION GIVEN BY:_____ DATE:_____

SITE:_____ INJECTION LOT#_____ & EXP:_____

1 MONTH INJECTION GIVEN BY:_____ DATE:_____

SITE:_____ INJECTION LOT#_____ & EXP:_____

6 MONTH INJECTION GIVEN BY:_____ DATE:_____

SITE:_____ INJECTION LOT#_____ & EXP:_____

___ CONTRACTOR REFUSED THE HEPATITIS B VACCINATION (SEE DECLINATION FORM).

_____
HEALTH CARE PROVIDER'S SIGNATURE