WINSTON Support Services, LLC

PHYSICAL EXAMINATION REPORT

Name _____ **Birthdate** _____ **Last four digits of Social Security** [ ][ ][ ][ ]

Address _____ **Phone #** _____ **Examination Date** _____

HISTORY

Operations _____

Injuries _____

Hernia _____

Acute / Chronic _____

Use of Narcotics / Meds / Alcohol / Tobacco _____

Hospitalizations _____

Allergies _____

Psychiatric / _____

Last Tetanus / Diptheria vaccination (within 10 Years) _____

Use of Assistive _____

PHYSICAL

Weight _____ Height _____ B / P _____ Pulse _____

Category	Normal	Abnormal	Comments	
Cognitive function				
Skin				
Glands				
Chest				
Heart				
Lungs				
Abdomen				
Arms / Legs				
Muscle Stretch				
Back				
Coordination / Reflexes				
Eyes			Snellen / Visual Acuity	OD _____ OS _____ OU _____
			Corrective Lenses	Yes _____ No _____
ENT			Isihara Color Acuity	_____ Plates of 14 Plates Pass ____ Fail ____
Forensic 10 Panel - Drug Test			Hearing Acuity	Right _____ Left _____

Mantoux 1 Given _____ Read _____ Results mm induration [-] _____ mm induration [+] _____

Mantoux 2 Given _____ Read _____ Results mm induration [-] _____ mm induration [+] _____

Respiratory Assessment ( ) Chest X-Ray Date _____ Results _____

QuantiFERON TB Gold Date _____ Results _____

Rubella Titer _____ Date _____ ( ) Immune ( ) Non-Immune

Rubeola Titer _____ Date _____ ( ) Immune ( ) Non-Immune

Varicella Titer _____ Date _____ ( ) Immune ( ) Non-Immune

Mumps Titer _____ Date _____ ( ) Immune ( ) Non-Immune

HBsAb _____ Date _____

HBsAg _____ Date _____ Hep B Declination _____ Date _____

I have examined _____ and determined that he / she is free of any health impairment which is of potential risk to patients or which might interfere with the performance of his / her duties.

_____ _____ _____

Signature **Date** **LIC#**

Physician's Name _____

(please print)

Physician's Phone _____

Physician's Address _____

_____

(This form is not valid unless stamped by MD / authorized provider.)

NOTE

ALL LAB REPORTS MUST BE ATTACHED!

STAMP HERE