FIVESTARCARE
Healthcare Staffing and Homecare
P 908 312 1423 - www.fivestar.care - F 908 325 1975
216 River Avenue Suite 207 Lakewood, NJ 08701

EMPLOYEE PHYSICAL EXAMINATION FORM

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Last Name:	**First Name:**	**Middle Initial:**	**Today's Date:**

MEDICAL HISTORY: Do you now have, or have you ever had, any of the following:

	YES	NO		YES	NO
1. Arthritis / Rheumatism			10. Hepatitis A; B; C; other Infections		
2. Asthma / Wheezing			11. Hernia(s)		
3. Back Injury/ Chronic Back Pain			12. Hypertension /High Blood Pressure		
4. Broken Bones / Fractures			13. Jaundice / Liver Disease		
5. Cancer			14. Sinus Trouble / Allergies		
6. Diabetes			15. Skin Disease		
7. Emphysema / Lung Disease			16. Stomach Trouble / GI Problems		
8. Head Injury / Unconsciousness			17. Substance Abuse (History of Drug or Alcohol Abuse Problems)		
9. Heart Disease / Heart Attack			18. Tuberculosis or History of Positive TB Skin Test		

I have read the above and declare that I have no injury, illness or ailment other than is specifically noted above. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

_____ _____

Employee's Signature Date

Any **"YES"** answer(s), **please explain below**.
Put the *number* (1, 2, 3, etc.) of the YES answer before the explanation:
(**Example**: *"#12. I have been taking medication for high blood pressure since 2007."*)

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PAGE 2

Last Name:	First Name:	Middle Initial:	Today's Date:	Job Title:

DOB	Age	Sex	HT	WT	Temp.	Pulse	Resp.	B/P	Drug/Food Allergies

Vision: R 20/____L 20/_____**Pupils:** Equal____Unequal____**Glasses/Lenses:** Y / N **Hearing:** ☐ Normal ☐ Impaired ☐ Hearing Aid

PHYSICAL EXAM	NORMAL	ABNORMAL	COMMENTS
1. General Appearance / BMI			
2. Skin			
3. HEENT			
4. Teeth			
5. Neck			
6. Lungs			
7. Heart			
8. Abdomen			
9. GU System			
10. Musculoskeletal Functioning (Full ROM to all extremities? History of injury to knees or hips?)			
11. Back / Spine (History of injury?)			
12. Neurological (Gross observation of gait, coordination, tremors, etc.)			
13. Psychiatric (tics, stuttering, nail-biting, cognition, orientation, affect, obvious personality disorders, etc.)			

Physician's review of person's medical history as recorded on reverse side of this form:_____

_____

_____

_____

_____

_____

PPD / Mantoux Test for Tuberculosis: 1st Step Date:_____ Result:_____ 2nd Step Date:_____Result: _____

Chest X-Ray: Date Performed:_____Results:_____

THIS APPLICANT IS FIT FOR EMPLOYMENT: YES: _____ NO: _____ Deferred for Functional Capacity Evaluation: _____

_____ _____

Examining Physician's Signature Date Physical Examination Performed