TRUECARE

EMPLOYEE ANNUAL PHYSICAL FORM - TO BE COMPLETED BY PROVIDER

Name: Sex: Date of Exam:

DOB: Social Security Number:

Physical Findings

Height:	Weight:	General Appearances:
Blood Pressure:	Pulse	Respiration:
Heart:	Lungs:	
G.I:	Musculoskeletal:	
Current Medications:		

(**ANNUAL TB SCREENING QUESTIONNAIRE **)
Please circle Yes or No

Are you experiencing unresolved respiratory symptoms ? Yes or No	Serious illness, hospitalization or significant injuries in the past year? Yes or No
Are you coughing up blood ? Yes or No	If yes, please specify:
Are you experiencing unexplained weight loss ? Yes or No	Have you visited any country EXCEPT Australia, New Zealand, Canada, U.S.A., Western Europe for MORE than one month? Yes or No
Are you experiencing increased sweating at night ? Yes or No	
Are you currently, or have you been immunosuppressed in the past? Yes or no	Have you had close contact with someone with Tuberculosis? Yes or no

**4 Panel Drug Screen lap Report Results Must Attach Documentation

Influenza Vaccine:	Lot #:	
Date Administration:	Expiration Date:	

Does this patient have any physical limitations: Yes: ☐ No: ☐

If Yes, explain any limitations in detail:

THIS PERSON IS FREE FROM ANY HEALTH IMPAIRMENT WHICH IS OF POTENTIAL RISK TO THE PATIENT OR WHICH MIGHT INTERFERE WITH THE PERFORMANCE OF HIS/ HER DUTIES, INCLUDING THE HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL OR OTHER DRUGS OR SUBSTANCES WHICH MAY ALTER THE INDIVIDUALS BEHAVIOR.

Provider's Signature:

Provider's License Number: Date:

MEDICAL STAMP

Please Note:

This document must be stamped with provider's official stamp and be accompanied by the required documentation. The physical form will not be accepted without the proper verification.

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