



HEALTH SCREENING

Name: _____ D.O.B. _____

Present Illness/Complaint/Disabilities: _____

Allergies: _____

Medicine currently prescribed and reason: _____

Has client been exposed to any communicable disease: Yes ___ No ___

If "yes" specify: _____

Past history of chronic or major illness: _____

Operations: _____

Hospitalizations: _____

Immunizations: Tetanus _____ Polio _____ Measles _____

Mumps _____ Rubella _____ Other _____

Respirations _____ Temperature _____

General appearance (include signs of drug abuse)

Nutrition: _____

Head: _____

Ears: _____ Hearing: R. _____ L. _____

Eyes: _____ Vision: w/o glasses R _____ L _____ with glasses: R _____ L _____

Nose: _____ Throat: _____ Mouth/Teeth: _____

Neck/Thyroid: _____ Chest: _____ Breast: _____

Cardiac: _____ Abdomen: _____ Genitalia: _____

Hernia: _____ Muscle/Skeletal: _____

Neurological: _____ Skin: _____

Required Lab Work

C.B.C. & Differential: _____

V.D.R.L. _____ Urinalysis: _____

Vaginal V D.R.L. _____ Pregnancy Test _____

Liver Function Tests: _____

RPR: _____

Hepatitis-A _____ Hepatitis-B _____ Hepatitis-C _____

T.B. Skin Test _____ Chest X-Ray (if T.B. pos.) _____

H.I.V. Antibody: _____

General Comments, Assessments, or recommendations on above: _____

Signature of examining Physician

Print Name of Examining Physician

Address

Phone Number

Date of Exam