Physical Exam Form

Patient Name:____________________________

Date of Birth: _______________________________

Name/Address/Phone # of Physician:

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Physical Examination

B/P _____________

Pulse ___________

Temp ___________

System	Normal	Abnormal
EENT		
Cardio		
Genitour		
Neuro		
Musculo		

System	Normal	Abnormal
Respiratory		
Gastro		
Endocrine		
Derma		
Phys. Abilities		

After examining this patient I have determined that he/she is free from malignant communicable or mental diseases and from any illness, defect or deformity which would impair or prevent the performance of duties, functions or responsibility, and the contractor is in good health sufficient to provide services to individuals with compromised health.

________________________ ____

Date **Signature of Examining Physician**

Results of PPD Skin Test:

Date: ___________________ **Site:** ___________________ **Admin By:** _______________

Date Read: ________________ **Results:** _________________ **Read By:** ________________

Expiration Date: ____________