PHYSICAL EXAMINATION FORM

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

TELEPHONE:	MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑	MALE ❑ FEMALE ❑	AGE _____ DATE OF BIRTH _____/_____/_____	SOCIAL SECURITY # _____

HEIGHT	WEIGHT	BLOOD PRESSURE	PULSE

TB SKIN TEST (PPD) _____/_____/_____ POSITIVE _____ mm/NEGATIVE _____

IF POSITIVE, CHEST XRAY _____/_____/_____ RESULTS: _____

PHYSICAL EXAM	RESULTS	EXPLANATION OF ABNORMALITIES	MEDICAL HISTORY
General			ALLERGIES:
Head, Face, Neck			
Eyes: Right: Left:			
Nose, Throat, Sinus			
Skin			
Head, Face, Neck			MEDICATIONS:
Eyes: Right: Left:			
Nose, Throat, Sinus			
Skin			
Heart			
Lungs, Chest, Breasts			
Abdomen			
Extremities			
Neurological			
Musculoskeletal System			

Is the patient pregnant? YES ❑ NO ❑

Can this applicant safely and effectively lift and move patients and perform the full duties of a nurses aid? YES ❑ NO ❑

Physicians Name:_____

Is the patient free of any communicable disease? YES ❑ NO ❑ Comments:_____

_____

_____

Examining Signature: _____ **Telephone:** _____ **Date:**_____/_____/_____