 **Well of Healing Mobile Medical Clinic**

Initial Employment Health Evaluation

**This form is for use as an initial health examination for participation in health care related activities**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| DATE: | | NAME: | | | | |
| DOB: | | Male  Female | | | RR: | SAO2: |
| AGE: | | WT: | HT: | | BMI: | |
| Allergies: | | Temp: | Pulse: | | Smoking? Yes No | |
| BP: (1st) | | **(2nd** if first elevated**)** | | |
| **PMHx/PSHx:** | | | **Medications:** | | | |
|  | | |  | | | |
|  | | |  | | | |
|  | | |  | | | |
|  | | |  | | | |
| HPI: *Screening Questionnaire*   1. Yes No Any new problem which is infectious or would prevent patient from performing assigned duties? 2. Yes No An unexplained weight loss in the last year? 3. Yes No A cough that has lasted 3 or more weeks? 4. Yes No Hemoptysis? 5. Yes No Unexplained fevers or night sweats? 6. Yes No Any of the following conditions which may impair the immune system or affect a response to a tuberculosis skin test?: Cancer, chemotherapy, sarcoidosis, HIV/AIDS, treatment with steroids or take medications for managing an organ transplant 7. Yes No Completed a TB skin test in the last 12 months? 8. Yes No A positive TB skin test? If so, has a chest xray been completed in the last 12 months? Yes No Date of xray: \_\_\_\_\_\_\_\_\_\_\_\_ 9. Yes No Completed vaccine series for Hepatitis B?   *(Patient is being asked to obtain a copy of their vaccine history including PPD result and if applicable, a copy of their CXR or QuantiFERON results)* | | | HPI: *Other* | | | |
| **Assessment:**  The volunteer/employee **IS ABLE** to perform assigned duties based on the assessed absence of a health condition that would create a hazard for volunteers, staff or to patients.  The volunteer/employee **IS NOT ABLE** to perform assigned duties based on the assessed presence of a health condition that would create a hazard for volunteers, staff or to patients.  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Physical Exam: | | | Orders:  Hepatitis B Vaccine Series | | | |
| General: | Well-dressed/nourished; No acute distress | |
| Eyes: | PERRL. EOM intact; conjunctiva & sclera clear | | PPD or Chest X-ray if indicated | | | |
| Ears: | Ext. canals clear – TMs normal | | QuantiFERON if indicated | | | |
| Nose & Throat: | Clear, MM pink, no lesions | | Other Orders:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name of Provider**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Signature** | | | |
| Chest: | Symmetrical | |
| Lungs: | Clear to auscultation bilaterally | |
| Heart: | Regular rate and rhythm; no murmurs, rubs, or gallops | |
| Abdomen: | Soft, non-distended, non-tender, no mass | |
| Additional Exam Notes or Abnormal Findings: | | |