PSA LLC Pre-Employment Health Assessment

Patient Name (print) _____ Exam Date ____/____/____
First Name Last Name

Patient Address _____
Street Apt # Borough Zip Code

Social Security #: XXX-XX- _____

Home Phone _____ Cell Phone _____

THIS IS A LIMITED PHYSICAL EXAMINATION FOR EMPLOYMENT PURPOSES ONLY.

CONSENT FOR EXAMINATION AND RELEASE OF INFORMATION:

Signature _____ Date: ____/____/____

Medical History	Yes	No
Recurrent Bloody Nose		
Bleeding Gums		
Blurred Vision/Nausea/Vomiting		
Recurrent Headaches		
Difficulty Walking Long Distances		
Shortness of Breath (SOB): With or without exertion		
Difficulty breathing while sleeping		
Swelling of Lower Extremities		
Seizure Disorder (History of Epilepsy)		
Dizziness/Fainting		
Chest Discomfort		
Weakness/Paralysis/Leg Pains		
Urination with burning or Blood		

Illnesses	Yes	No
Tuberculosis/Hepatitis/Malaria		
Measles/Mumps/Rubella		
Chicken Pox		
Syphilis/Gonorrhea		
Asthma		
Diabetes		
Allergies		
COPD		
Surgery		
Other Medical illnesses		
Sickle Cell Trait/Disease		
Depressants/Stimulants		
Narcotics		
Alcohol/Smoker		
Present/Medications:		

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Physical Examination

Height: _____ Pulse: _____
Weight: _____ Blood Pressure: _____ LMP: _____

	ABN	WNL		ABN	WNL
Skin			Throat/Neck		
Eyes			Heart		
Ears			Lungs		
Nose			Back		
			Extremities		

PPD/Mantoux Date: / / Date Read: / / Results: _____ MM

TB Screen: [ ] ABN [ ] WNL Referral _____
Chest X-Ray*: [ ] ABN [ ] WNL Referral _____
*Attach copy

Laboratory Tests (see attached)

	Immune	Non-Immune	Copy of results	Date
Rubella				
Rubeola				
Drug Screen				

Limitations

[ ] Fully-Employable – No limitations
[ ] Not Currently Employable – recommend additional testing/treatment and/or follow-up asap for:

MD Name (print) _____ Signature _____ License # _____ Phone # _____

H/A -#41

Stamp