Trulife Health Services

Employee/ contactor physical examination

(Needs to be completed within 30 days of employment)

NAME:..... **PHONE:**.....

ADDRESS:.....

PHYSICAL EXAMINATION AGE:..... **TEMPRATURE:**..... **PULSE:**..... **RESPIRATION:**.....

BLOOD PRESSURE:..... **SYSTOLIC:**..... **DIASTOLIC:**.....

WEIGHT:.....

X:FINDINGS ARE NORMAL **O: FINDINGS ARE ABNORMAL**

SKIN:..... **CHEST:**.....

HEAD EYE:..... **BREAST:**.....

EARS: ..... **HEART:**.....

NOSE: ..... **LUNGS:**.....

MOUTH: ..... **BLOOD VESSLES:**.....

THROAT:..... **ABDOMEN:**.....

NECK: ..... **EXTREMITIES:**.....

LYMPH NODES:..... **NETUROLOGICAL:**.....

IS PATIENT FREE FROM COMMMICABLE? **Yes**..... **No**.....

Are there other conditions you feel would adversely affect this individual from carrying out his/her duties in a residential or other community program for disabled individual? Yes..... **No**.....

can the patient lift a 50lbs or more weight? **Yes**..... **No**.....

TB test Result: **Positive** ..... **Negative**.....

Date:.....

Hepatitis B Test Result:..... **Date:**.....

Physician's Name:.....

Stamp & Signature of examining physician:.....

Phone Number:..... **Date:**.....