Geriatric Resource Consultants LLC Annual Physical Examination

Name: _____ Date of Birth: _____ Sex: ☐Male ☐Female

Address: _____ S S #: _____ Title: _____

System Name	Normal findings		Tuberculosis (TB) Screen – History and PPD : This section must be completed if PPD is Positive		
Head/ENT	☐ Yes	☐ No	Chest Pain	☐ Yes	☐ No
Eyes	☐ Yes	☐ No	Lingering Cough	☐ Yes	☐ No
Neck	☐ Yes	☐ No	Loss Of Energy	☐ Yes	☐ No
Breasts	☐ Yes	☐ No	Unexplained Weight Loss	☐ Yes	☐ No
Lungs	☐ Yes	☐ No	Flu Like Symptoms	☐ Yes	☐ No
Cardiovascular	☐ Yes	☐ No	Increase Sweating at Night	☐ Yes	☐ No
Musculoskeletal	☐ Yes	☐ No	Low Grade Fever	☐ Yes	☐ No
Abdomen	☐ Yes	☐ No			
Genitourinary	☐ Yes	☐ No			
Central Nervous System	☐ Yes	☐ No			

If yes to any of the above please explain:

GENERAL PHYSICAL EXAMINATION

Blood Pressure: _____/_____ **Pulse:** _____ **Respirations:** _____ **Temp:** _____ **Height:** _____ **Weight:** _____

LABORATORY TEST RESULTS			
Test	Date Performed	Results – Must provide Lab Value	
Rubella Titer		_____non immune _____ immune	Lab value _____
Measles Titer		_____non immune _____ immune	Lab value _____
Drug Screen: Min 5 Panel Must Include Lab Report		_____ Positive _____Negative	

Test	Date Implanted	Date Read	Results (mmmm)
PPD (Annually)			
PPD (Annually)			
Chest X-Ray (+ PPD)			
IMMUNIZATIONS			
Immunization	Date	Date	Date
Rubella			
Rubeola/Measles			
Hepatitis B Vaccine			
Influenza Vaccination*		**If declined please complete Declination Form*	

_____This individual is free from any health impairment that is a potential risk to the patient or other employee(s) or which may interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol.

_____This individual is able to work with the following limitations: _____

_____This individual is not physically/mentally able to work. Specify: _____

_____ _____ _____

Name of physician *(please print)* **Physician's Signature** **Date**

Physician Address: _____ **Physician Phone Number:** _____

License No./Stamp: _____