MATCH ONE STAFFING

205-07 Hillside Avenue
Suite# 26
Hollis, N.Y. 11423
Phone:[718] 217-1666
Fax# [718] 217-1667

Physical Examination Report

NAME: DATE OF PHYSICAL:

ADDRESS: SOCIAL SECURITY:

HEIGHT: WEIGHT: DATE OF BIRTH:

LABORATORY RESULTS

Tuberculin Test-PPD Date Administered____ Date Read____ Result____

2nd Step (If positive) Date Administered____ Date Read____ Result____

Quantiferon Gold Date Administered____ Date Read____ Result____

Chest X-Ray Date____ Results____

Mumps, Measles, Rubella Immunization date:____ Titer Results: Must be in a lab printout

Varicella Zoster Immunization date:____ Titer Results: Must be in a lab printout

Tetanus & Dipthertia Date:____

Hepatitis Results:
(HepBAg/HepBAb / HepCAb) Vaccine#1____ Vaccine#2____ Vaccine#3____

Flu Vaccine Immunization date:____ Location :____ Lot#:____

Lab Results for MMR/Varicella/ Hepatitis Titers must be attached, as well as results form a Drug Screening.

EVALUATION OF SYSTEMS:	Findings:		Comments / Description
Eyes	☐ Yes	☐ No	
Ears	☐ Yes	☐ No	
Nose	☐ Yes	☐ No	
Mouth/Throat	☐ Yes	☐ No	
Head/Face/Neck	☐ Yes	☐ No	
Breasts	☐ Yes	☐ No	
Lungs	☐ Yes	☐ No	
Cardiovascular	☐ Yes	☐ No	
Extremities	☐ Yes	☐ No	
Abdomen	☐ Yes	☐ No	
Gastrointestinal	☐ Yes	☐ No	
Endocrine	☐ Yes	☐ No	
Musculoskeletal	☐ Yes	☐ No	
Integumentary	☐ Yes	☐ No	
Renal/Urinary	☐ Yes	☐ No	
Reproductive	☐ Yes	☐ No	
Lymphatic	☐ Yes	☐ No	
Nervous System	☐ Yes	☐ No	

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Tuberculosis Screen Form

NAME_____ DATE OF PHYSICAL_____

LAST PPD (DATE AND RESULTS)_____

LAST X-RAY (DATE AND RESULTS)_____

Do you or have you had Diabetes Mellitus?	☐Yes	☐No
Do you or have you had Blood or Lymph Disease?	☐Yes	☐No
Do you take Corticosteroids (prednisone, cortisone)?	☐Yes	☐No

If yes, please explain_____

_____

Are you taking any immunosuppressive drugs?	☐Yes	☐No

If yes, please explain_____

_____

Do you have any of the following symptoms?

Fever	☐Yes	☐No
Tiredness/ Weakness	☐Yes	☐No
Night Sweats	☐Yes	☐No
Loss of Appetite	☐Yes	☐No
Unexpected Weight Loss	☐Yes	☐No
Cough with Phlegm	☐Yes	☐No
Blood Tinged Phlegm	☐Yes	☐No

Applicant is able to work without restrictions?	☐Yes	☐No
Patient is free of all communicable diseases?	☐Yes	☐No

If no, please explain_____

_____

PHYSICAN'S SIGNATURE _____ **DATE**_____

PHYSICIAN'S NAME (Print or Stamp) _____ **LICENSE#**_____

ADDRESS _____

TELEPHONE#_____