Phone: 718-615-0049
Fax: 877-547-3464 (credentials only)

Physical Examination Report

Patient Name: ____ Exam Date: _________________________

Date of Birth:_______________________ Sex: ________ Height: ____________BP: ________________

General Appearance________________________________Skin____________________________________

Heart _________________________Lungs _______________________ Abdomen____________________

ENT _________________________ Extremities ______________________ Back _____________________

Eyes______________________________________Reflexes____

Disabilities (if any) ____

Serology ____Date ___________________________________

Urology ____ Date ___________________________________

<u>Items in bold print are mandatory for work:</u>

History of Vaccination:

Rubella (German Measles)	**Rubeola (Measles)**	**Mumps**	**Varicella (Chicken Pox)**
Titer_____________ Date of Vaccine _______________	**Titer_____________ Date of Vaccine ________________**	**Titer_____________ Date of Vaccine __________________**	**Titer_____________ Date of Vaccine __________________**

Tuberculosis History:

PPD(Mantoux): Date administered____________________Results_____________________

If history of positive PPD, Chest X-ray Required -

Date of X-Ray _______________________ Results__________________________

Is examinee free from health impairments that may interfere with performance of his/her duties?

YES __________ NO ___________

I certify that I have examined the above named individual and have found his/her health to be satisfactory to work in the health care field.

Signature: __________________________________,M.D. Date: _________________________

Physicians' Stamp and License Number: