Phone: 718-615-0049
Fax: 502-213-9550 (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 _____

Items in bold print are mandatory for work:

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 they/their duties?

YES _____ NO _____

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

Signature: _____,M.D. Date: _____

Physicians' Stamp and License Number: