PROFESSIONAL NURSING SERVICE

EMPLOYEE HEALTH RECORD

A completed, signed Employee Health Record is required by Professional Nursing Service for health care employees. You must complete and sign Sections I-IV. Your primary care provider must complete and sign Section V.

You cannot begin work for PNS until we receive this Employee Health Record completed and signed.

I. Name_____ Position_____

Address_____

Date of Birth_____ S.S.#_____

II. Please indicate with a check if you have or had any of the following:

	Head Injury		Cough(chronic)/Hemoptysis		Communicable Disease/TB
	Headaches		Dental/Gum Disease		Sexually Transmitted Disease
	Epilepsy/Seizures		Lip/Oral Lesions		Joint Disease/Change in ROM
	Speech Changes/Impairment		Sore Throat/Tongue		Spinal Disease/Back Pain
	Addiction Drug/Alcohol		Difficulty Chewing/Swallowing		Muscle/Coordination Abnormalities
	Behavioral Counseling/Disorders		Thyroid/Endocrine Disease		Parasthesia/Paralysis
	Skin Disease/Allergies		Weight Change		Dizziness/Lightheadedness/Syncope
	Rashes/Lesions/Lumps		Breast Disease/Pain/Lumps		Foot Disease/Problems
	Environmental/Occupational Exposure		Chest Pain/Palpitations		Kidney/Renal Disease
	Visual Impairment/Disturbances		Heart Disease/Rhythm Abnormalities		Bowel Disease/Hernia
	Ear Pain/Discomfort/Discharge		Cramps/Edema/Pain in Legs		Varicosities
	Nasal Stuffiness/Drainage		Blood Pressure Problems		Menstrual Irregularities
	Epistaxis		Changes in Bowel/Bladder		Cyanosis/Shortness of Breath
	Upper Respiratory Infections		Abdominal Pain/Ulcers		Genitourinary Irregularities

If you checked any of the above, please explain:_____

_____

III. Medical History (Past ten years)

A. Are you under the care of a physician/primary care provider: Yes_____ No_____
If yes, reason(s)_____

B. Are you taking medications? Yes_____ No_____
If yes, type:_____

C. Have you had any operations or hospitalizations for illness? Yes_____ No_____
If yes, explain and give dates_____

D. Have you had any accidents requiring medical attention: Yes_____ No_____
If yes, explain and give dates_____

E. Are you willing to have blood/urine screening for drugs/alcohol as a condition of employment?
Yes_____ No_____
If no, explain_____

IV. Complete the following and attach copies of results.

	DATE	RESULTS		DATE	RESULTS
A. Chest X-ray (Pos PPD only)	_____	_____	E. * PPD(Tuberculin)	_____	_____
			F. Tetanus Booster	_____	_____
B. Rubella Titre	_____	_____	G. Hepatitis B Vac. 1	_____	_____
C. Rubeola Titre	_____	_____	H. Hepatitis B Vac. 2	_____	_____
D. Varicella Titre	_____	_____	I. Hepatitis B Vac. 3	_____	_____

* Test (if positive, referral for chest x-ray required)

I understand that I must have an annual health screening and annual PPD to retain active employment with Professional Nursing Service. I hereby give my permission to release the results of any test and/or information regarding my health status to Professional Nursing Service.

_____ _____
Employee signature Date

V. To be Completed by Health Examiner

PHYSICAL EXAM

Date:_____ Blood Pressure:_____Height:_____Weight:_____

Exam Results and Comments on Employee Medical History (see Sections I and III)

_____

_____

RN Signature:_____ **Date:**_____

I certify that the above person, to the best of my knowledge, is in good physical and mental health, free from symptoms indicating the presence of an infectious disease and any condition which would interfere with the performance of his/her duties which may require: assistance with transfers; supporting patient during ambulation; providing personal care; and skilled nursing function.

Primary Care Provider Signature:_____ **Date:**_____