

HANDS ON SURGICAL ASSISTANTS ANNUAL PHYSICAL

CONTRACTOR: _____ DATE: _____

ANNUAL HEALTH STATEMENT (TO BE COMPLETED BY CONTRACTOR):

NAME CHANGE SINCE LAST PHYSICAL YES NO

ADDRESS: _____

TELEPHONE #: _____

EMERGENCY CONTACT: _____

LIST ANY ALLERGIES OR SENSITIVITIES TO DRUGS, SOAP, GLOVES, ETC:

LIST ALL MEDICATIONS TAKEN REGULARLY: _____

LIST ANY HEALTH CHANGES SINCE LAST PHYSICAL:

UNEXPLAINED WEIGHT LOSS	YES	NO
UNEXPLAINED LOSS OF APPETITE	YES	NO
PRODUCTIVE COUGH (FOR MORE THAN 3 WEEKS)	YES	NO
BLOODY SPUTUM	YES	NO
NIGHT SWEATS (NOT RELATED TO MENOPAUSE)	YES	NO
CHRONIC FATIGUE	YES	NO
SWOLLEN GLANDS (TYPICALLY IN NECK)	YES	NO
CHANGE IN DENTAL STRUCTURE	YES	NO
SURGERY IN THE PAST YEAR	YES	NO
PHYSICAL LIMITATIONS	YES	NO
ANY COMMUNICABLE DISEASES	YES	NO
ANY SERIOUS ILLNESS (EPILEPSY, DIABETES, ETC)	YES	NO
LOSS OF SIGHT OR UNCORRECTED VISION	YES	NO
CARDIOVASCULAR DISORDERS	YES	NO
PSYCHONEUROTIC DISABILITY FOLLOWING TREATMENT	YES	NO
PERMANENT INJURY WHICH CONSTITUTES 20% IMPAIRMENT	YES	NO

PLEASE EXPLAIN ANY "YES" ANSWERS IN THE ABOVE SECTION:

I CERTIFY THAT ALL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

CONTRACTOR'S SIGNATURE: _____

ANNUAL HEALTH STATEMENT (TO BE COMPLETED BY HEALTH CARE PROVIDER)

B/P _____ P _____ SAO2 _____ HT _____ WT _____ HGB _____

TB SCREENING:

PPD: GIVEN BY: _____ DATE: _____

SITE: _____ INJECTION LOT# _____ & EXP: _____

PPD MUST BE READ BY A PHYSICIAN OR RN 48 TO 72 HOURS AFTER ADMINISTRATION

RESULTS: _____ DATE READ: _____ NEXT DUE: _____

SIGNATURE AND TITLE OF PERSON READING THE TEST

CHEST X-RAY: DONE BY: _____ DATE: _____

RESULTS: _____ DATE READ: _____ NEXT DUE: _____

SIGNATURE AND TITLE OF PERSON READING THE TEST

HEPATITIS SCREENING:

HEPATITIS B SURFACE ANTIBODY POSITIVE DATE: _____

SIGNATURE AND TITLE OF PERSON READING THE TEST

IF HEPATITIS B SURFACE ANTIBODY IS NEGATIVE, RECOMBIAX IS REQUIRED

INITIAL INJECTION GIVEN BY: _____ DATE: _____

SITE: _____ INJECTION LOT# _____ & EXP: _____

1 MONTH INJECTION GIVEN BY: _____ DATE: _____

SITE: _____ INJECTION LOT# _____ & EXP: _____

6 MONTH INJECTION GIVEN BY: _____ DATE: _____

SITE: _____ INJECTION LOT# _____ & EXP: _____

CONTRACTOR REFUSED THE HEPATITIS B VACCINATION (SEE DECLINATION FORM).

HEALTH CARE PROVIDER'S SIGNATURE

