

HEALTH SCREENING FORM

TO BE COMPLETED BY MEDICAL PROVIDER ONLY

Today's Date: _____

Name _____ D.O.B. _____

Present Illness/Complaint/Disabilities, if any: _____

Allergies: _____

Medicine currently prescribed and reason: _____

Has client been exposed to any communicable diseases: No Yes, specify _____

History of chronic or major illness: _____

Operations: _____

Hospitalizations: _____

Physical Examination Code: Satisfactory = S Unsatisfactory = U Not Examined = O

Height _____ Weight _____ B/P _____ Pulse _____ Resp _____ Temp _____

General Appearance (including schemata of drug abuse)

Nutrition _____ Head: _____ Ears _____ Hearing: R _____ L _____

Eyes _____ Vision:(w/out glasses) R _____ L _____ (with glasses) R _____ L _____

Nose _____ Throat _____ Mouth/Teeth _____ Neck/Thyroid _____

Chest _____ Cardiac _____ Abdomen _____ Genitalia _____

Hernia _____ Skin _____ MusculoSkeletal _____ Neurologic _____

Tests (*Attach computer printout of all test results)

TB Test only (\$12) _____ results: _____

Lab/Blood work(check all that are done)

VP/Blood draw (\$7.00)

Urinalysis (81003,\$4.80)

RPR (86592,\$10.00)

Hep ABC (80074,\$45.00)

Urine Pregnancy (81025, \$15.00)

Hep B Core(86705,\$12.20)

Chest xray (\$58)

HIV(86701,\$15.00)

Optional Tests: CBC _____ Liver Function _____

Comments, recommendations: _____

Signature of Provider _____

Address: _____ City, State, Zip: _____

Phone: _____

DENTAL EXAM: Please CIRCLE	
Needed work was done:	Yes No
No further work is needed at this time:	Yes No
Further work is needed soon:	Yes No
_____	_____
Dentist Signature	Phone Number