City Pro Group, Inc. **2625 East 14th Street Brooklyn, NY 11235 Phone (718)769-2698 Fax (718) 943-7035**

Annual Health Assessment (Physical examination)

Name: _____RN/LPN/PT/OT/COTA/CSW/SLP/SI
Address: _____ Social Security # : ____-____-_____
Phone: _____

I. Past Medical /Psychological History

Tuberculosis: *no( ) Yes( )*
Diabetes: *no( ) Yes( )*
Heart or Cardiovascular Disease: *no( ) Yes( )*
Hypertension: *no( ) Yes( )*
Cancer: *no( ) Yes( )*
Kidney Disease: *no( ) Yes( )*
Allergies: *no( ) Yes( ) If yes, state*_____
Epilepsy or Seizure disorder: *no( ) Yes( )*
Drug/Alcohol abuse or addiction: *no( ) Yes( )*
Psychiatric or Behavioral Disorder: *no( ) Yes( )*
*Other*_____ *Are you now taking medications? If so, for what?* _____

Examiner, please complete the following:
II. Mandatory Immunizations and Lab tests. Exact titre number must be given as requested.

Diphtheria _____*(Unless given in the last 10 years)*
Tetanus _____*(Unless given in the last 10 years)*
*PPD(Mantoux)*_____*Date* _____*Results:*_____*date:*_____
*Rubella titre*_____*Or screen*_____*date*_____
*Results: ( ) immune ( ) not immune ( ) rubella vaccine (If needed):*_____
*Rubeola titre*_____*Or screen*_____*date*_____
*Results: ( ) immune ( ) not immune ( ) rubeola vaccine (If needed):*_____
Hepatitis B: ( ) immune ( ) not immune ( ) immunization contraindicated
*Vaccine dates:*_____ _____ _____

III. Lab Tests
CBC: _____ *results*_____*date*_____
*Urinalysis:*_____*results*_____*date*_____
***** Chest X -RAY Mandatory if PPD (MANTOUX) is positive!!!**

IV. Review of Systems by Examiner:

Head/Neck _____
EENT _____
Resp. _____
Cardiovasc. _____
ABD - GI _____
GU _____
Musc-skel _____
Neuro _____
Endocrine _____
Skin _____

V. Medical Examiner:

I hereby certify that the above named patient does not have any limitations for employment in the health care field and contract with patient and other staff. There is no health impairment present that is of potential risk to the employee, patient, family or other employees, or that may interfere with the performance of duties.

Physician's signature: _____ ***Physician's name***_____
Address:_____
Date _____ ***Phone:*** _____