



PEACE & JOY HOME CARE

PHYSICIAN CLINICAL EXAMINATION

(732) 851-8049 | www.peacenjoyhomecare.com

Name _____ Date of Birth _____ Date of exam _____
Address _____ City _____ State _____ Zip _____

EXAMINATION

Check each item if normal; otherwise explain.

BP _____	Temp _____	Pulse _____	Respiration _____	Weight _____	Height _____
1. General	☐	_____	9. Thorax/Lung	☐	_____
2. Skin	☐	_____	10. Cardiac	☐	_____
3. Head	☐	_____	11. Abdomen	☐	_____
4. Eyes	☐	_____	12. Back	☐	_____
5. Ears	☐	_____	13. Extremities	☐	_____
6. Nose	☐	_____	14. Musculoskeletal	☐	_____
7. Mouth/Throat	☐	_____	15. Neurological	☐	_____
8. Neck	☐	_____	16. Psychiatric	☐	_____

DIAGNOSIS AND ASSESSMENT OF MEDICAL PROBLEMS

☐ No medical problems ☐ Ongoing medical problems (explain): _____

LIMITATIONS / RECOMMENDATIONS

☐ No limitations ☐ Limitation(s), explain: _____

MANDATORY IMMUNIZATION / TEST

☐ TUBERCULOSIS: PPD (Mantoux) skin test only.

Tine test unacceptable. Previous BCG vaccination does not negate the need for PPD testing.

PPD #1 Date given _____ Date read _____ Result _____ mm

PPD #2 Date given _____ Date read _____ Result _____ mm

- OR - QUANTIFERON TB GOLD or T-SPOT BLOOD TEST Date _____ Result _____

Dated blood test results MUST be attached.

If PPD or Quantiferon positive: Chest X-ray is required; copy of X-ray report MUST be included.

Date _____ Result _____ (Enclose report copy)

Provider instructions: All dates must include month, day and year. Mark (X) the appropriate boxes.

MMR (measles, mumps, rubella) - combined immunization		Month	Day	Year
☐ Dose 1: Immunized after 1 year of age and after 1972				
☐ Dose 2: Immunized after 1972 and at 5 years of age or older				
OR: Vaccination / titers (dated titer lab results MUST be attached)				
☐ Measles (Rubeola) Titer level _____	☐ Vaccination			
☐ Rubella Titer level _____	☐ Vaccination			

PHYSICIAN CERTIFICATION

After examination as required and to the best of my knowledge, I have determined that this individual is free from any health impairment that is of potential risk to patients or which might interfere with the performance of his/her duties. This includes the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior or judgment.

Examining physician (print) _____

Signature of examining physician _____

Telephone _____

Date _____

Physician stamp

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