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A6.0 ANNUAL HEALTH ASSESSMENT

PATIENT NAME: _____ **DOB:** _____ **DATE OF EXAM:** _____

1. Are you being treated for any health problems? Yes ____ No ____
   If yes, please explain: _____

2. Are you taking any medication regularly at this time? Yes ____ No ____
   If yes, what kind and why: _____

3. Have you had any injuries/illnesses during the past year? Yes ____ No ____
   If yes, please explain: _____

4. Have you had any hospitalizations and/or surgery during the past year? Yes ___No ___
   If yes please explain: _____

5. Are you addicted to depressants, stimulants, narcotics, alcohol or any other drug or substance that may alter behavior or impair the performance of your duties?
   Yes ____ No ____

6. Do you have any allergies? Yes ___ No ___
   If yes, to what: _____

Indicate by a check if you have experienced and/or been treated for any of the following:

Rheumatic Fever ____ Diabetes ____ Asthma ____ Dermatitis ____ Heart Disease ____
Seizures ____ Fainting ____ Bleeding Problems ____ Angina ____ Shortness of Breath ____
High Blood Pressure ____ Menstrual Problems ____ Tuberculosis ____ Headaches ____

I certify to the best of my knowledge that I am free from any health impairment that may be of potential risk to the patient or may interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter my behavior. I also certify that the information on this form is accurate.

_____
Patient Signature

TO BE COMPLETED BY HEALTHCARE PROVIDER:

RUBELLA	**RUBEOLA**
Date of Immunization:_____	Date of Immunization:_____
Numeric Titer Level:_____(required)	Numeric Titer Level:_____(required)

PPD

Date Given:	Date Read:	Results : Level:
Chest X-Ray (if positive PPD)	Date:	

On the basis of my examination and the information above, I find the above person fit to give adequate care at this time and is free from all communicable disease.

Healthcare Providers Name (Print) _____License #._____
(Clinical Supervisor if NP or PA)

Address: _____

Provider's Signature: _____ Date:_____

** **New York State Department of Health requires each therapist to have an annual health assessment**. **
(Please complete this form with the help of your Health Care Provider)

CONFIDENTIAL ANNUAL SELF- HEALTH ASSESSMENT

TUBERCULIN SCREENING QUESTIONNAIRE

TO BE COMPLETED BY THE PROVIDER

This form is a screening tool for purposes of employment. It is not a substitute for obtaining regular medical examinations and care by your personal healthcare professional.

Name: _____ Date: _____

Address: _____ Phone (home/cell): _____

E-Mail address: _____

Department: _____ Title: _____

Emergency Contact: _____ Relationship: _____ Telephone: _____

1. Since your last medical assessment/physical, have you had any change in your medical status? ☐ No ☐ Yes
2. Within the past year, have you had any of the following:

Injury	☐ No	☐ Yes	Asthma/bronchitis	☐ No	☐ Yes	Back pain	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes	Fainting spells	☐ No	☐ Yes	Musculo-skeletal	☐ No	☐ Yes
Surgery	☐ No	☐ Yes	Heart trouble	☐ No	☐ Yes	Hernia	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes	Migraine headaches	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Sinus trouble	☐ No	☐ Yes	Skin disease	☐ No	☐ Yes	Thyroid disease	☐ No	☐ Yes
Allergies	☐ No	☐ Yes	Chronic Cough	☐ No	☐ Yes	Chronic infections	☐ No	☐ Yes
Nervous disorder	☐ No	☐ Yes	High blood pressure	☐ No	☐ Yes	Digestive disorder	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Kidney disease	☐ No	☐ Yes	Other:	☐ No	☐ Yes

If yes to any of these, please describe: _____

Tuberculin Screening Questionnaire

1. Have you received a prior diagnosis of active TB or latent TB infection or a positive skin test or blood test for TB? No Yes
2. Have you been treated for latent TB infection? No Yes
3. Have you been treated with medication for TB or for a positive TB test? No Yes
4. **Within the past year, did you have any of the following?**

☐ No ☐ Yes 1) history of temporary or permanent residence (for >1 month) in a country with a high TB rate; (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)

☐ No ☐ Yes 2) Current or planned immunosuppression; including human immunodeficiency virus infection, receipt of an organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone >15mg/day for >1 month) or other immunisuppressive medication;

☐ No ☐ Yes 3) close contact with someone who has had TB disease.

5. **Within the past year, did you have any of the following symptoms?**

Chronic cough	☐ No	☐ Yes	Night sweats	☐ No	☐ Yes	Weight loss	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes	Fever	☐ No	☐ Yes	Loss of appetite	☐ No	☐ Yes

I certify to the best of my knowledge that I am free from any health impairment that may be of potential risk to the patient or may interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances that may alter my behavior. I also certify that the information on this form is accurate.

Provider's Signature: _____

This section to be completed by a physician, nurse practitioner, physician's assistant or RN: Requires further evaluation or follow-up TB test indicated?(circle one) No Yes

Examining Medical Provider or RN Reviewer - _____

Signature: _____ Title: _____ Date: _____