Caritas
Home Health Providers, Inc.

ANNUAL PHYSICAL EXAMINATION

NAME: _____ DATE: _____

HEIGHT: _____ WEIGHT: _____ BODY TYPE: _____ SEX: ____ AGE: ____

BP: _____ TEMP: _____ PULSE: _____ RESPIRATION: _____

PLEASE INDICATE IF WITHIN NORMAL LIMITS OR ABNORMAL

EYES: _____

EARS: _____

NOSE: _____

THROAT: _____

MOUTH/TEETH/TONGUE: _____

THYROIDS: _____

NECK: _____

SKIN: _____

HAIR/SCALP: _____

LUNGS: _____

HEART: _____

TB CLEARANCE: PPD skin test results: (check applicable results & record measurements)

No reaction: _____

Erythema diameter: _____(mm)

Induration: _____(mm)

Date of Result: _____

I have examined the above-named individual and found him/her free from communicable disease. This person is physically and mentally qualified to perform work.

PHYSICIAN'S NAME: _____ PHONE: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

ADDRESS: _____

_____