Statement of Good Health

To be completed by employee (Please Print in Ink)

Personal Data		
Name (Last, Frist, MI)		Date of Birth
Address		
City	State	Zip Code
Position	Home Phone	Cell Phone

Medical History Questionnaire

Have you had any of the following?

	Yes	No		Yes	No		Yes	No
Arthritis			Heavy Metal Poisoning			Psychoneurotic Disability		
Arteriosclerosis			Hemophilia			Rheumatism		
Asthma			Hepatitis			Ruptured in Vertebral Disc		
Back Injury			Hernia			Scoliosis		
Cerebral Palsy			Hypertension			Sinus Trouble		
Chicken Pox			Ionizing Radiation Injury			Skin Disease		
Chronic Back Pain			Jaundice			Stomach Trouble		
Diabetes			Measles			Thrombophlebitis		
Epilepsy			Multiple Sclerosis			Tuberculosis		
Fainting Spells			Muscular Dystrophy			Varicose Veins		
Fractures			Operations			Vision Loss		
Head Injury			Polio					
Heart Trouble								

If any answer is yes to any of the above, explain:

Are you currently being treated for any illness/injury? If yes, describe/state duration:	☐ Yes	☐ No
Have you ever been hospitalized for any illness/injury? If yes, for what/when/duration:	☐ Yes	☐ No
What drug(s) do you use currently or regularly? If yes, for what kind?	□ Yes	□ No
Do you have any long-term disability or any limitations due to health? If yes, describe condition and limitation:	□ Yes	□ No
Do you have any allergies? If yes, what are you allergic to?	□ Yes	□ No

Employee Print Name _____ Classification / Department _____

Employee Signature _____ Date _____

Statement of Good Health

To be completed by physician (Please Print in Ink)

IMMUNIZATION RECORDS

PPD SKIN TEST RECORD

Step	Date Placed	Lot #	Expiration	Site	Administered By	Date Read	Read By	Results	Status
1st								mm	□ Reactor □ Non-Reactor □ Converter
2nd								mm	□ Reactor □ Non-Reactor □ Converter

CHEST X-RAY RECORD

Positive PPD Test	Date Placed:	Date Read:	Results: mm
Chest X Ray	Date Taken:	Date Read:	Results:

MEASLES (RUBEOLA) RECORD

Vaccine #1	Date Placed:	OR	Titer	Date Received:	□ Immune □ Non-Immune □ Equivocal
Vaccine #2	Date Placed:				

MUMPS RECORD

Vaccine #1	Date Placed:	OR	Titer	Date Received:	□ Immune □ Non-Immune □ Equivocal
Vaccine #2	Date Placed:				

RUBELLA RECORD

Vaccine	Date Placed:	OR	Titer	Date Received:	□ Immune □ Non-Immune □ Equivocal

VARICELLA RECORD

Vaccine #1	Date Placed:	OR	Titer	Date Received:	□ Immune □ Non-Immune □ Equivocal
Vaccine #2	Date Placed:				

HEPATITIS B RECORD

Vaccine #1	Date Placed:	OR	Titer	Date Received:	□ Immune □ Non-Immune □ Equivocal
Vaccine #2	Date Placed:				
Vaccine #3	Date Placed:				

OTHER RECORDS

Tetanus-Diphtheria (Td) Record	Acellular Pertussis (Tdap) Record	Seasonal Influenza Record
Date Placed:	Date Placed:	Date Placed:

I certify that _____ has been seen in my office. A Physical
Employee Name

Examination confirms that the patient is in good health, free from communicable diseases, and is able to work with no restrictions.

_____ _____
Physician, PA, or NP Print Name Date of Physical Examination

_____ _____
Physician, PA, or NP Signature Telephone Number

_____
Address

_____ _____ _____
City State Zip Code