FOUR SEASONS
IN-HOME SERVICES

Health Assessment

Name _____ **Date** _____

County _____ **Date of Hire:** _____

Vital Signs:

B/P	T	P	R

Lungs:	R	L
CTA:	____	____
Wheeze:	____	____
Crackles:	____	____

Heart:	Reg	Irr
RAD:	____	____
AP:	____	____

ENT:	Yes	No
Ears Clear	____	____
Eyes Clear:	____	____
Nose Drainage:	____	____
Congestion:	____	____
Throat Clear	____	____
Cough	____	____
Soreness	____	____

Tuberculosis:	Yes	No
Previous positive Tuberculin Skin Test?	____	____
Have you ever had Tuberculosis?	____	____
Are you allergic to PPD?	____	____
Are you allergic to eggs?	____	____
Are you pregnant or breast feeding?	____	____
Chest X-Ray Needed?	____	____

Skin:	Yes	No
Hands free of sores	____	____
Scalp free of lice	____	____

X _____
EMPLOYEE SIGNATURE

To my knowledge this employee appears to be free of Communicable Disease:

X _____
NURSE SIGNATURE

_____ _____
Date of Test Site

_____
Given By

_____
Date Read

Results: mantoux mm ____

_____
Read By