Astonishing Caregiving Service LLC
639 Main St Stroudsburg PA 18360
Phone: **570-977-570** • Fax: **570-215-2482**
Email: **astonishagency1@gmail.com**

TB SCREEN

TUBERCULOSIS QUESTIONNAIRE

Employee Name:_____Evaluation Date:_____

Since the employee has a history of a positive Tuberculosis Skin Test, Home Health Care Service 0f NY requires an annual screening questionnaire is be completed by a physician. If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

1.	Chronic Cough	☐ YES	☐ NO
2.	Fever	☐ YES	☐ NO
3.	Night Sweat	☐ YES	☐ NO
4.	Unexplained Weight Loss	☐ YES	☐ NO
5.	Hemoptysis (coughing blood)	☐ YES	☐ NO
6.	Hoarseness	☐ YES	☐ NO
7.	Wheezing	☐ YES	☐ NO
8.	Shortness of Breath	☐ YES	☐ NO
9.	Chest Pains	☐ YES	☐ NO

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons whom are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

Care requires a chest x-ray be completed and on file within 30 days of any newly reported positive PPD results, and every 10 years thereafter.

Physician/RN Name: _____Physician/RN Signature: _____

LICENSE #: _____Date of fast Chest X-ray: _____

DOCTOR / RN Stamp below:

Essentially, repeated chest x -ray of asymptomatic tuberculin reactors, whether or not they have completed preventative therapy, is no longer recommended.

DOH publication (FDS) 83-82-4.

CDC Personal Health Guideline" AJIC, June 1998, Volume26 , p.318. Revised 12/8/2016 .

ANNUAL PHYSICAL EXAMINATION FORM

NAME: _____ DATE OF BIRTH: _____

1. PAST MEDICAL/PSYCHOLOGICAL HISTORY:

Tuberculosis:	No	Yes	Epilepsy or seizure disorder:	No	Yes
Diabetes:	No	Yes	Drug alcohol abuse or addiction:	No	Yes
Heart or Cardiovascular Disease:	No	Yes	Psychiatric or Behavioral Disorder:	No	Yes
Hypertension:	No	Yes	Other: _____		
Cancer:	No	Yes	Are you now taking medicines? If so, for what?		
Kidney Disease:	No	Yes	_____		
Allergies (if yes, specify below):	No	Yes	_____		

II. MANDATORY VACCINE IMMUNIZATION AND LAB TESTS (TO BE COMPLETED BY DOCTOR)

PPD (MANTOUX)
DATE GIVEN:
DATE READ:
RESULTS:
NEGATIVE: mm POSITIVE: mm

AND

DRUG SCREEN (at least 9 drugs)
DATE DRAWN:
RESULTS:
☐ NEGATIVE
☐ POSITIVE

Attach lab work report required!

IF POSITIVE, PROVIDE CHEST X-RAY RESULTS: DATE RESULTS

RUBELLA: MMR BOOSTER (if needed)

DATE: _____ DATE: _____
TITER: _____ LOT#: _____
RESULT: _____ EXP. DATE:
IMMUNE NOT IMMUNE

AND

if born after January 1, 1957:
RUBEOLA: MMR BOOSTER (if needed)

DATE: _____ DATE: _____
TITER: _____ LOT#: _____
RESULT: _____ EXP. DATE:
IMMUNE NOT IMMUNE

Attach lab work report required!

III. FLU VACCINE: DATE GIVEN: _____

IV. REVIEW OF SYSTEMS (TO BE COMPLETED BY DOCTOR)

HEAD/NECK:	ABD - GI:	ENDOCRINE:
EENT:	GU:	SPIN:
RESP:	MUSK - SKEL:	HEIGHT:
CARDIOVASC:	NEURO:	WEIGHT:

V. DOCTOR

I hereby certify that the above named patient does not have any limitations for employment in the health care field, and contact with patients ally other staff. There is no health impairment present that is of potential risk to the employee, patient, family, or other employees, or that may interfere with the performance of his or her duties. I have questioned the patient and see nothing to contradict the patient's assertion that he or she is not habituated or addicted to antidepressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE _____ EXAM DATE: _____

DOCTOR'S NAME (PRINT)_____PHYSICIAN'S LICENSE #: _____

PLEASE USE
PHYSICIAN'S STAMP