Pre-Employment Medical Form
TRI-MED

Demographic Information

First Name	Last Name	SSN:	Title:
Address:		DOB:	Gender: M F NB

Vital Signs:

Ht.	B/P	Temp.
Wt.	Pulse	Resp

Physical Assessment

System	WNL	Comments
HEENT		
Lungs		
CNS		
Cardiovascular		
Musculoskeletal		
Genitourinary		
Abdomen		

Tuberculosis:

☐ **Patient has a history of positive TB**

PPD Dose #1 (First Step)	**PPD Dose #2** (withing three weeks of 1 step)
Date Implanted: _____	Date Implanted: _____
Date Read: _____	Date Read: _____
Result: _____ mm	Result: _____ mm
☐ Negative ☐ Positive	☐ Negative ☐ Positive
QuantiFERON (if done instead of PPD)	**PPD Dose #2** (If positive PPD)
Date Done: _____ Result:	Date Done: _____ Result:
☐ Negative ☐ Report Attached (required)	☐ Negative ☐ Report Attached (required)

TB Questionnaire:

Unexplained Fever	Y / N	Fatigue/Tiredness for More than 3 Weeks	Y / N
Unexplained Chills for 1 or More Weeks	Y / N	Prolonged (Chronic) Cough longer than 3 Weeks	Y / N
Unexplained Drenching Night Sweats	Y / N	Been Diagnosed with active and /or latent TB, positive skin test or positive	Y / N
Persistent Shortness of Breath	Y / N	Been treated with medication for TB or for a positive TB test or, treated for latent TB	Y / N
Unexplained Weight Loss	Y / N	Have you come in close contact with anyone who is/was sick with TB	Y / N
Persistent Chest Pain	Y / N	Current or planned immunosuppression including HIV, recipient of an organ transplant, Chronic steroids	Y / N
Coughing up Blood	Y / N	History of temporary/permanent residence greater than 1 month in a country with high TB rate excluding U.S., Canada. Australia, New Zealand, northern/western Europe	Y / N

Immunization: (LABORATORY TEST RESULTS MUST BE ACCOMPANIED BY LAB

Rubella	**Rubeola/Measles**	**Annual Flu Shot** (October -May)
Titer Number:_____ ☐ Titer Report Attcahed (Required) ☐ Immue ☐ Not Immune Booster MMR Vaccine _____ (Date given)	Titer Number:_____ ☐ Titer Report Attcahed (Required) ☐ Immue ☐ Not Immune 1ST MMR Vaccine: _____ (Date given) 2nd MMR Vaccine _____ (Date given)	Name: _____ Lot#_____ Date Given: _____ Exp Date:_____ OR Decline ☐

Physican's Acknowledgement:

Please select of the following:

☐ This individual is free from any health impairment that is a potential risk to the patient or to another employee or which may interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, alcohol or other drugs, or substances which may alter the individual's behavior.

☐ This individual is able to work with the following limitation: _____

☐ This individual is not physically/mentally able to work (specify reason): _____

Physician's Name : _____

Physician's Signature: _____

Today's Date: _____

(Physician's Stamp /Required)