Annual Contracted Vendor Health Screening

Date of Screening: _______________

Employee Name (printed)	
Allergies	
Changes	❑No changes to previous years health screening ❑changes (describe: ____ ____
Current Health Issues	❑hypertension ❑diabetes ❑asthma ❑chf ❑cad ❑immunocompromised ❑pregnant ❑other: ____
Past Health Issues	❑hypertension ❑diabetes ❑asthma ❑chf ❑cad ❑immunocompromised ❑Other: ____
Person to contact in case of Emergency and relation to employee	
Date of Tuberculin Testing and results	Date of PPD______________Date Read______________ Results: _______mm negative / positive (circle either) ____ Date of Chest X-ray if unable to do TB testing:_________________ Results: ___________________ Being followed by Dr. ____________________(if applicable)
Immunization Status	❑history of chicken pox/shingles (age: ______________) ❑varicella vaccination (date:_______________) ❑hepatitis b series (dates: ____________________________) ❑measles, mumps, ruebella vaccination (date: ________) ❑tetanus (date: __________________) ❑pneumonia (date: _______________) ❑influenza (date: _________________) ❑other: _________________________/date: _____________

Employee Signature: ________________________________

Physician/Midlevel Printed Name: ____

Physician/Midlevel Signature: ________________________________Date of Screening: ____________