TOWN OF NANTUCKET

EMPLOYEE HEALTH EVALUATION

Please complete FAMILY HISTORY, IMMUNIZATION & MEDICAL HISTORY SECTIONS:

____

LAST NAME FIRST NAME MI

Date of Birth________________ Female____ Male____ Other_____

Position applied for______________________________ Employment Date: _______________

FAMILY HISTORY:

Check if condition exists in your immediate family, grandparents, aunts, uncles, cousins:

_____Allergies _____Anemia _____Asthma _____Bleeding disorder
_____Cancer _____TB _____ Diabetes _____Eye disorder
_____Heart disease _____High Blood Pressure _____Ulcer
_____Lung Disease _____Mental Illness _____Stroke _____Sudden Death
_____Other: ____

Prior Surgeries: ____

Medications: ____

Allergies: ____

IMMUNIZATION HISTORY: (give dates if possible)

	VACCINATED	HISTORY OF ILLNESS
Measles	____________	____________
Mumps	____________	____________
Rubella	____________	____________
Chicken Pox	____________	____________
Diphtheria/Tetanus (booster)	____________	____________
Polio	____________	____________
Hepatitis B	____________	____________
Influenza	____________	____________
Pneumococcal	____________	____________

Have you received a pension, insurance payments, or compensation for an injury or illness?

____

____

Have you had any major accidents or injury?

____

____

____

MEDICAL HISTORY:

Please check yes or no to indicate whether you currently have (or have had in the past) the following health concerns:

	YES	NO		YES	NO
Allergies	_____	_____	Ulcers	_____	_____
Anemia	_____	_____	Heart murmur	_____	_____
Anxiety	_____	_____	Hepatitis/liver disease	_____	_____
Asthma	_____	_____	High blood pressure	_____	_____
Bleeding disorder	_____	_____	Kidney infection/stone	_____	_____
Visual Impairment	_____	_____	Learning disability	_____	_____
Cancer/malignancy	_____	_____	Lung disease	_____	_____
Depression	_____	_____	Migraine headaches	_____	_____
Diabetes	_____	_____	Palpitations	_____	_____
Eating disorder	_____	_____	Pneumonia	_____	_____
Mental health	_____	_____	Rheumatic fever	_____	_____
GI disorder	_____	_____	Scarlet fever	_____	_____
Head injury	_____	_____	Seizure disorder	_____	_____
with Unconsciousness	_____	_____	Sinusitis	_____	_____
Thyroid DX	_____	_____	Hearing impairment	_____	_____
Tuberculosis	_____	_____	Heart disease	_____	_____

MEDICAL EXAM:

AGE ______ HEIGHT _______ WEIGHT ________ PHYSICAL DEVELOPMENT _____________

NUTRITIONAL STATUS ___________________ BP _______/_______ PULSE ________________

SKIN__________________ EYES______________ SCLERA ___________ PUPILS ____________

GLASSES______________ EARS __________________ CANALS __________________________

DRUMS:*(RIGHT)* ________ *(LEFT)*_________ NOSE _______________ SEPTUM _____________

TURMINATES__________ MOUTH ______________ LIPS ____________ TONGUE___________

PHARYNX _________ NECK __________ MOBILITY_________ LYMPH NODES ____________

THYROID_________ LUNGS ________ HEART ________ RATE ________ RHYTHM_________

MURMUR ___________ ABDOMEN ____________ LIVER ___________ SPLEEN ____________

HERNIAS ____________ GYNECOLOGICAL/URINARY _____________ SPINE ______________

LOWER EXTREMITIES ________ ROM _______ DEVELOPMENT _______ STRENGTH ______

UPPER EXTREMITIES _________ ROM _______ DEVELOPMENT _______ STRENGTH ______

CRANIAL NERVE _____________ I-XII _______ GAIT _________ COORDINATION __________

I have examined the above employee/candidate for employment and found him/her fit for duty and free from communicable disease.

**Please note that only a Medical Professional can sign off on this form.*

Printed Name of MD/ANP/PA: ____

Signature of MD/ANP/PA: _____________________________________ Date: ________________