Tennessee Baptist Children's Homes

EMPLOYEE MEDICAL and TB SKIN TEST REPORT

In our efforts to provide safe, well-screened environment, TBCH requests that a complete family health history and current physical examination are required as an essential part of the evaluation.

First Name	Middle	Last Name

		☐ Male ☐ Female	
Date of Birth	Social Security Number	Sex	Race

Special Needs or Disabilities: ______________________________

Current Medications & Dosage: *(List all prescription and over-the-counter medications you are currently taking.)*

____

Allergies (medication, food, insect stings, etc.) ☐ Yes ☐ No Specify: ______________________________

Special Diet: ______________________________

FAMILY HEALTH HISTORY *(please check appropriate box of family member for all that apply)*

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease/Heart Attack	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Blood/Circulatory Problems	☐	☐	☐	☐	☐	☐
Sickle Cell Disease/Trait	☐	☐	☐	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Hepatitis/Liver Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Bone/Joint Disorder	☐	☐	☐	☐	☐	☐
Infectious Disease	☐	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐	☐
Alcohol/Drug Use	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Other Medical Conditions	☐	☐	☐	☐	☐	☐

Explain any checked items ______________________________

Please list the name and age of each child ______________________________

____

Are your parents living? ☐ Yes ☐ No Siblings? ☐ Yes ☐ No Children? ☐ Yes ☐ No

Name, Age at Death and Cause of Death ______________________________

MEDICAL/PHYSICIAN INFORMATION

Do you have a regular medical provider? ☐ Yes ☐ No

If yes, please provide name of medical provider ______________________________

MENTAL HEALTH

Have you ever been treated or hospitalized for a mental illness or suicide thoughts/attempts?

☐ Yes ☐ No

If yes, list date(s) and hospital ______________________________

Have you ever had a psychological evaluation? ☐ Yes ☐ No

If yes, list date(s) and provider ______________________________

ALCOHOL/DRUG HISTORY and FREQUENCY

☐ Alcohol ______________________________ ☐ Hallucinogens ______________________________

☐ Marijuana ______________________________ ☐ Sedatives ______________________________

☐ Barbiturates ______________________________ ☐ Steroids ______________________________

☐ Amphetamines ______________________________ ☐ Tobacco ______________________________

☐ Huffing ☐ Other

PHYSICAL EXAM **(To be Completed by the Physician)**

Height ________ **Weight** ________ **Temp** ________ **Resp.** ________ **B/P** ________

Vision: Right 20/______ Left 20/______ **Hearing:** Right ☐ Pass ☐ Fail Left ☐ Pass ☐ Fail

Unclothed Physical Exam ☐ Partial ☐ Complete

	Normal	Abnormal	Comments
General Appearance – Nutrition, activity level, hygiene, emotion, behavior	☐	☐	
Skin – color, scars, eruptions, piercings, tattoos	☐	☐	
Head – scalp, hair loss, injury	☐	☐	
Eyes – redness, discharge, pupils	☐	☐	
Ears – hearing, TMs, canals, foreign bodies	☐	☐	
Nose – congestion, noisy breathing, discharge	☐	☐	
Mouth/Throat – palate, teeth, gums, breathing	☐	☐	
Neck – stiffness, thyroid	☐	☐	
Lymph Nodes/Glands – swelling, tenderness	☐	☐	
Lungs/Chest – breath sounds, nipples	☐	☐	
Heart/Circulatory – rate, rhythm, murmur	☐	☐	

Abdomen – masses, tenderness	☐	☐	
Genitourinary	☐	☐	
Musculoskeletal – ROM, gait, coordination, scoliosis	☐	☐	
Neurological – tremors, seizures, headaches	☐	☐	
Rectal Exam	☐	☐	
Pelvic Exam	☐	☐	

TB ASSESSMENTS

☐ **TB (PPD)** Date: ______________________ Results: ______________________________

☐ **CBC** ☐ **Metabolic Panel** ☐ **Cholesterol** ☐ **Urine Analysis** ☐ **VDRL/GC/Chlamydia** ☐ **Other**

Applicant is free of communicable disease(s) ☐ Yes ☐ No

If no, please explain ____

Specify any physical, mental, or emotional problems which would affect this person's ability to care for a child. If the person is identified as other adult living in the home, indicate conditions detrimental to a child's placement in the home.

On the basis of this examination and my knowledge of this patient, I ☐ recommend ☐ do not recommend this person as a care giver for children.

Comments:

Physician Name: ________________________________

Physician Signature: ________________________________ Date: ______________________