Professional Healthcare Educators

1286 Kalani St. B-204, Honolulu, Hawaii 96817 / Phone (808)847-3366

PHYSICAL EXAMINATION

PRINT Name:_______________________________________ Sex: M/ F Marital Status: ___
Complete Address:____
Date of Birth: _______________Age: _____ Home Phone: __________________ Work Phone:______________
In case of emergency, please contact: ____________________________________ Relationship: _____________

1. Have you been exposed to any communicable diseases that you know of lately? ___________________
   If yes, please describe/date. ____
2. Do you have any history of back pains, back surgery, leg pains, that would prohibit you from lifting, turning, or performing job description of a nursing assistant? ____________________________________
   ____
3. For Females: Do you think you could be pregnant? _______ If yes, LMP: __________ EDC: _________
4. Any history of depression or mental illness: ____________
   If yes, please describe: ____
5. Any history of substance abuse, alcoholism, or violent behavior? __________
   If yes, please describe: ____

TO BE COMPLETED BY PHYSICIAN OR A NURSE PRACTITIONER

1. List medications you are taking, dosage, and reason.
   ____
   ____
2. Restrictions/pain/disabilities noted by the physician/nurse practitioner
   ____
   ____
3. Previous surgeries/date.
   ____
   ____
4. Physicians/nurse practitioner's findings.
   ____
   ____
5. TB Testing required. Should be current within 12 months.

   Date done:__________________ Results:_______________________ CXR: ____________________

After examining the above patient, I hereby declare that he/she has no restrictions to perform the duties of a nursing assistant.

PHYSICIAN/NURSE PRACTIONER: ____DATE: ______________

SIGNATURE: _________________________CLINIC/OFFICE ADDRESS: _______________________________

Please release copy of this physical exam to Professional Healthcare Educators

Print Name: ____________________________ Signature: _______________________ Date: ______________