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CDPAP SELF ANNUAL HEALTH ASSESSMENT

NAME:	DATE OF BIRTH:	SSN (Last 4):
ADDRESS:	PHONE:	

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS BELOW SINCE YOUR LAST ASSESSMENT?

	NO	YES		NO	YES
Migraine Headaches?			Frequent Colds Or Other Respiratory Problems?		
Change in Energy Level?			Chest Pain/Pressure In Chest		
Swelling in Legs/Feet?			Unintentionally Lost or Gained Weight?		
Back Pain?			Pain When Urinating Or Blood In Urine?		
High Blood Pressure?			Persistent Lumps Or Sores?		
Fainting or Dizziness			Surgery In The Past Year?		
Change In Bowel Habits?			Illnesses Or Injuries In the Past Year?		
Loss Of Appetite?			Medications that could Interfere with your Job? IF YES, List Below:		

MEDICATION LIST

MEDICATION NAME	STRENGTH	FREQUENCY	ROUTE (EX: MOUTH)	CONDITION MEDICATION TAKEN FOR

TUBERCULOSIS SCREENING QUESTIONAIRE

	NO	YES		NO	YES
Chest Pains			Night Sweats For No Known Reason		
Blood-Streaked Sputum			Persistent Shortness of Breath		
Unexplained Weight Loss			Chronic Cough (greater than 3 weeks)		
Fever/Chills			Fatigue/Tiredness for more than 3 weeks		

BASELINE INDIVIDUAL TB RISK ASSESSMENT	NO	YES
History of temporary or permanent residence (for>1 month) in a country with a high TB rate		
Do you have any medical condition, or are taking any medications, which suppress your immune system?		
Have you been in contact with anyone with active tuberculosis disease in the past year?		

<u>Are you free</u> from the habituation or addiction to alcohol, depressants, stimulants, narcotics, or other drugs or substances with may alter your behavior?

YES □ Initials: _____ NO □ Initials: _____

<u>Are you free</u> from any health impairments which are of potential risk to a patient or which might interfere with the performance of your duties and free of communicable diseases?

YES □ Initials: _____ NO □ Initials: _____

I have read the above and declare that I have no injury, illness, or ailment other than as specifically identified that may interfere with the performance of my job responsibilities. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

EMPLOYEE SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

I the undersigned, have reviewed this self health assessment with full knowledge that the above individual was found to be:

□ ***<u>Fit for Duty</u>***

□ ***<u>Not Fit for Duty</u>*** - Individual was advised of the need of a physical evaluation with physician to be completed by _____

RN SIGNATURE: _____ DATE: _____

This self health assesment is not valid if you develop new symptoms. Moreover, new signs or symptoms should prompt urgent evaluation with your physician and immediate notification to Marks Home Care Agency.