NSA LLC NURSE STAFFING AGENCY

NSA Physical and Health Evaluation Form - History

(Note: This form is to be filled out by the employee prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________________________

Gender ____________________ Age ________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

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Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes
1. Do you classify yourself as physically disabled?	
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ______________	
3. Have you ever spent the night in the hospital?	
4. Have you ever had surgery?	
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**
5. DO you feel tired with the least activity?	
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during any activity?	
7. Does your heart ever race or skip beats (irregular beats) during any activity?	
8. Has a doctor ever told you that you have any heart problems? If so, explain.	
9. Do you get lightheaded or feel shorter of breath than expected during an activity?	
10. Do you get more tired or short of breath more often than usual ?	
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**
11. Has any family member or relative (living or dead) have or had heart problems or had an unexpected or unexplained sudden death (including drowning, unexplained car accident, or sudden infant death syndrome)?	
BONE AND JOINT QUESTIONS	**Yes**
12. Have you ever had an injury to a bone, including spine or muscle?	
13. Have you ever had a fracture?	
14. Do you use any assistive device?	
15. Do any of your joints become painful, swollen, feel warm, or look red?	

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during orafter exercise?		
17. Have you ever used an inhaler or taken asthma medicine?		
18. Is there anyone in your family who has asthma?		
19. Do you have a history of seizure disorder?		
20. Do you have frequent headaches?		
21. Have you ever had numbness, tingling, or weakness in your arms orlegs?		
22. Do you get frequent muscle cramps during activity?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you had any problems with your eyes or vision?		
25. Have you had any eye injuries?		
26. Do you wear glasses or contact lenses?		
27. Do you worry about your weight?		
28. Are you trying to or has anyone recommended that you gain orlose weight?		
29. Are you on a special diet or do you avoid certain types of foods?		
30. Do you feel stressed out or under a lot of pressure?		
31. do you ever feel sad, hopeless, depressed or anxious?		
32. Do you feel safe at your home or residence?		
33. Do you smoke?		
34. Do you drink alcohol or use any drugs?		
FEMALES ONLY		
35. When was your last menstrual period?		
36. Have you had a pap smear?		
37. Are you pregnant or trying to get pregnant?		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Employee's Signature ______________________________ Date ______________________________

NSA LLC
NURSE STAFFING AGENCY

PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Cleared for work without restriction
Cleared for light duty

Cleared for all work without restriction with recommendations for further evaluation or treatment for ______________________________

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Not cleared

I have examined the above-named employee and completed the full physical evaluation. The employee does not present apparent clinical contraindications to practice. A copy of the physical exam is on record in my office and can be made available to the employer at their request.

Pending further evaluation

For any activity

For certain activities ______________________________

Reason________Recommendations ______________________________

Name of Healthcare practitioner______________________________Date of exam ______________

Address______________________________Phone______________

I have examined the above-named employee and completed the preparticipation physical evaluation. The employee does not present apparent clinical contraindications to practice.
A copy of the physical exam is on record in my office and can be made available to the agency at the request of the employer. If conditions arise after the employee has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completelyexplained to the employee.

Signature of Healthcare practitioner ______________________________

NSA LLC
NURSE STAFFING AGENCY

CLEARANCE FORM

Name ____________________ \ Gender ____________________ Date of birth ____________________

☐ Cleared for all work without restriction

☐ Cleared for all work without restriction with recommendations for further evaluation or treatment for ____________________

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☐ Not cleared

☐ Pending further evaluation

☐ For any work

☐ For certain work ____________________

Reason_______Recommendations ____________________

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EMERGENCY INFORMATION

Allergies ____________________

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Other information ____________________

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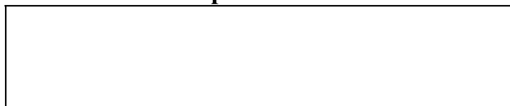
I have examined the above-named employee and completed the preparticipation physical evaluation. The employee does not present apparent clinical contraindications to practice and participate in the activities as outlined above. A copy of the physical exam is on record in my office and can be made available to the agency at the request of the employer. If conditions arise after the employee has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the employee.

NSA Office stamp



Name of healthcare practitioner____________________Date____________________

Address____________________Phone____________________

Signature of physician, APN, PA ____________________

Date____________________Signature____________________