Continuum Health Partners, Inc.
Long Island College Hospital — Primary Clinical Teaching Affiliate of SUNY—Health Science Center at Brooklyn

LICH POST-GRADUATE TRAINEE
PHYSICAL EXAMINATION REPORT

(please print firmly and clearly)

NAME:_____ **SOC.SEC.#**_____-_____-_____
(LAST) (FIRST) PGY LEVEL: _____

DEPARTMENT_____ **COUNTRY OF ORIGIN:**_____
HOME ADDRESS_____ **HOME TELEPHONE:**_____-_____-_____
_____

TO BE COMPLETED BY PHYSICIAN CONDUCTING THE EXAMINATION

SEX: M____ F____ AGE:____ DOB:___/____/_____ Weight:_____Height:_____ B.P._____

Previous Medical And Surgical Hx:_____
_____

Family Illness:_____

General Appearance:_____

PHYSICAL EXAMINATION:

HEENT:	**_____WNL**	**Comments**_____
Neck:	**_____WNL**	**Comments:**_____
Heart:	**_____WNL**	**Comments:**_____
Lungs:	**_____WNL**	**Comments:**_____
Abdomen:	**_____WNL**	**Comments:**_____
Skin:	**_____WNL**	**Comments**_____
Lymph Nodes:	**_____WNL**	**Comments:**_____
Extremities	**_____WNL**	**Comments:**_____
Neurology:	**_____WNL**	**Comments:**_____

IMMUNIZATIONS AND VACCINATIONS:

PPD Hx(P or N): PPD#1Date:_____;Result [ ] Manufacturer:_____ Lot#_____
_____ Induration_____mm
BCG History: Yes [ ]No [ ] If positive PPD positive must submit documentation regarding induration.
INH Prophylaxis: Yes[ ] No [ ]
CXR Date:____/____/____ CXR Result:(must attach report if PPD Pos) _____
Tetanus/Diphtheria booster (within 10 years): Date:____/____/_____
Hepatitis B Vaccine Dates:#1____/_____/___;#2____/____/_____;#3_____/____/____ ; Declined :____

*LABS: (PLEASE ATTACH HARD COPIES OF LAB DATA):

Measles Ab_____ Measles vaccine date: ____/_____/_____
Mumps Ab_____ Mumps vaccine date: ____/_____/_____
Rubella Ab_____ Rubella vaccine date: ____/_____/_____
Varicella Ab_____ Varicella vaccine dates: #1_____/____/_____ #2____/_____/_____

HBSAG_____ HBSAB_____

M.D. (Print):_____ **DATE**_____
M.D.(Signature):_____
Address:_____ **Phone: _____/_____/_____**
M.D. License # _____