HSG Health History Form

Applicant name: _____ DOB: _____ Date: _____

Tuberculosis Screening

TB/PPD Placement	Date Placed:	Arm: R ____ L ____	Given by:	Induration in mm:
	Date Read:	Result Neg: ____ Pos:____	Read by:	
Chest X-Ray*	Date Read:	Result Neg: ____ Pos:____		

*Attach copy of the radiology report and a copy of the +PPD reading.

Immunization Status

Vaccination	**Date Given**	**Vaccinator (Signature & Title)**
TDaP		
MMR #1		
MMR #2		
Hepatitis B #1		
Hepatitis B #2		
Hepatitis B #3		
Varicella #1		
Varicella #2		
Titer	**Date Resulted**	**Result**
Mumps Titer		___ Immune ___ Not Immune
Rubella Titer		___ Immune ___ Not Immune
Rubeola (Measles) Titer		___ Immune ___ Not Immune
Hepatitis B Titer		___ Immune ___ Not Immune
Varicella Titer		___ Immune ___ Not Immune ___History

Physician Statement

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable diseases, and able to function without physical limitations as a healthcare professional.

_____ _____ ❑ MD ❑ NP ❑ PA ❑ DO

Signature Date

_____ _____

Printed Name Phone Number

_____

Facility Name Address City, State Zip Code

Last Revised: 3/2018