RICHMOND HOME CARE AGENCY
COMPASSIONATE CARE AT THE COMFORT OF YOUR HOME

1375 Bay St Staten Island, NY 10305
Phone: 718-273-5211
Email: Richmondhca@gmail.com

EMPLOYMENT HEALTH ASSESTMENT

☐ **Pre-employment** ☐ **Annual Assessment** ☐ **Other:**

Name:	Marital Status: ☐ S ☐ M ☐ D ☐ W	Sex: ☐ M ☐ F
Address.	DOB:	Title:
Emergency Contact:	Relationship:	
Emergency Address:	Telephone	

INDICATE ILLNESS EXPERIENCED BY YOU OR FAMILY HISTORY			HAVE you HAD ANY ILLNESS BELOW SINCE LAST ASSESSTMENT		
CONDITION	YES	NO	CONDITION	YES	
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS 15+LBS OR MORE		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT COUGH		
TUBERCULOSIS			BLOOD SPUTUM		
MENTAL ILLNESS			SHORTNESS OF BREATH		
EPILEPSY/CONVULSIONS			CHEST PAIN/PRESSURE IN CHEST		
CANCER			SWELLING IN LEGS/FEET		
LATEX ALLERGY			PAIN IN CALF WHEN WALKING		
Do you smoke? ☐ Yes ☐ No			CHANGE IN BOWEL HABITS		
			BACK PAIN		
			PAIN WHEN URINATING OR BLOOD IN URINE		
Is yes how many packs a day?			HIGFÖBLOOD PRESSURE		
			INFEXTIOUS DISEASE		
			INCREASED THIRST		
			PERSISTANT SORES OR LUMPS		
Do you drink alcoholic beverages? ☐ Yes ☐ NO			If yes, how much?		

Do you take depressant, narcotic drugs that alter your behavior? □ Yes □ No If yes. Specify:

Do you take prescription medications? □ Yes, If yes, list below:
Name of your physician?
Address:
I have read 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.
Signature: Date: