NAVAJO HEAD START
EMPLOYEE HEALTH EVALUATION FORM
CONFIDENTIAL

Part I **Employee Information** (employee completes this information)

Name: _____ Contact Number: _____

Address: _____

Date of Birth: _____ Age: _____ Sex: _____

Job Title: _____

Purpose of Evaluation: ☐ Pre-Employment ☐ Annual Evaluation ☐ Returning to Work After Injury

Circle the number preceding each functional requirement essential to the duties of this Job title.

1 Heavy lifting, 45 pounds and over	7 Use of fingers	13 Both legs required for coordination simutaneously
2 Moderate lifting, 15-44 pounds	8 Both hands required	14 Reaching above shoulder
3 Light lifting, under 15 pounds	9 Walking	15 Climbing, use of legs and arms
4 Heavy carrying, 45 pounds and over	10 Standing	16 Both eyes required
5 Moderate carrying, 15-44 pounds	11 Crawling	17 Hearing
6 Light carrying, 15-44 pounds	12 Kneeling	18 Repeated bending

Brief Description of what the job title requires:

Part II **Health History** (employee completes this information)

Do you have or have you ever had:

Yes	No	
☐	☐	Any illness or injury in last 5 years?
☐	☐	Head/Brain injuries, disorders, or illnesses
☐	☐	Seizures, epilepsy ☐ Medication _____
☐	☐	Eye disorders or impaired vision (except corrective lenses)
☐	☐	Ear disorders, loss of hearing or balance
☐	☐	Heart Disease or heart attack; other cardiovascular condition ☐ Medication _____
☐	☐	Heart surgery(valve replacement/bypass, angioplasty, pacemaker)
☐	☐	High blood pressure ☐ Medication _____
☐	☐	Muscular disease
☐	☐	Shortness of breath
☐	☐	Asthma, lung disease, emphysema, chronic bronchitis
☐	☐	Kidney disease, dialysis
☐	☐	Liver disease
☐	☐	Digestive problems
☐	☐	Diabetes or elevated blood sugar ☐ Diet/Exercise ☐ Pills ☐ Insulin
☐	☐	Nervous or psychiatric disorders, e.g., severe depression ☐ Medication
☐	☐	Loss of, or altered consciousness
☐	☐	Fainting, dizziness
☐	☐	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
☐	☐	Stroke or paralysis
☐	☐	Missing or impaired hand, arm, foot, leg, finger, toe
☐	☐	Spinal injury or disease
☐	☐	Chronic low back pain
☐	☐	Regular, frequent alcohol use
☐	☐	Regular, frequent tobacco use
☐	☐	Narcotic or habit forming drug use

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Part II - continued

Employee Name: _____ Job title: _____

Do you have or have you ever had:

Yes	No	
☐	☐	Tuberculosis (T.B.)
☐	☐	Hernia
☐	☐	Allergies to medications, food, pollen, etc.
☐	☐	Skin problems (including eczema, rash, ringworm, etc.)

For any "YES" answers, please explain here:

I certify that the above information is complete and true. I understand that inaccurate, false, or missing information may invalidate the examination.

_____ _____

Employee Signature Date

PART III TESTING (Medical Examiner completes the remaining sections below)

Height: Weight:	Blood Pressure: Systolic: Diastolic:
Hct/Hgb: WBC:	Pulse Rate: ☐ Regular ☐ Irregular
Urine Specimen: Specific Gravity:	Protein: Blood: Sugar:
PPD:	Chest X ray Results (if applicable)

Vision:

Acuity	Uncorrected	Corrected
Right Eye	20/	20/
Left Eye	20/	20/
Both Eyes	20/	20/

Hearing: Record distance from individual at which forced whispered voice can first be heard.

Right ear: ft Left ear: ft

Examiners comments:

Check one:

_____ Employee is ready to perform his/her job title.

_____ Employee will need further health evaluation/follow up. Comment/appointment: _____

Medical Examiner Name	Medical Examiner Signature			Date of Exam
Address	City	State	Zip code	Phone Number

Revised 5/2011