Consumer Directed Choices, Inc.
7 Washington Square
Albany, NY 12205

Telephone 518-464-0810
Fax 518-690-7153
Email Health@CDChoices.org

ANNUAL HEALTH ASSESSMENT

Name		**Phone**	
Address		**Date of Birth**	

MEDICAL HISTORY (TO BE COMPLETED BY THE PERSONAL ASSISTANT)

Have you had work restrictions due to injury or illness? If yes, please explain:

How do you consider your present health? (please circle) **Excellent** **Good** **Fair** **Poor**

PHYSICAL EXAM:	**YES**	**NO**		**YES**	**NO**
Limitations with Lifting			Skin		
Fever/Night Sweats			H/E/E/N/T		
Allergic to Latex			Neck		
Hypertension			Heart/Lungs		
Drug/Alcohol Habitual Use/Abuse			Abdomen		
Persistent Chest or Back Pain			Extremities		
Currently Using Tobacco			Neurological/Muscular		
Hearing Impairments			Allergies		
Asthma			Hx of Chicken Pox		
History of Hepatitis			History of Tuberculosis		
Immunizations or Injections			Other		
Fainting, Blackouts, Dizziness			Diabetes, Thyroid, Anemia, Cancer		
Convulsions, Headaches			Fractures, Arthritis, Bursitis		

PLEASE EXPLAIN ANY "YES" ANSWERS BELOW

OVER **OVER** **OVER** **OVER** **OVER**

Personal Assistant Name: _____DOB _____

Tuberculosis (TB) Risk Assessment **REQUIRED**	**YES**	**NO**
Unexplained Fatigue lasting more than 3 weeks		
Lack of Appetite		
Unexplained Weight Loss		
Fever/Chills/Drenching Night Sweats		
Productive Cough lasting more than 3 Weeks		
Coughing up blood		
Chest Pain		
Traveled or temporarily resided in a country with a high TB rate within the last month		
Currently undergoing immunosuppression (including organ transplant, HIV infection, or chronic steroids)		
Had a TB test or chest x-ray performed in the past? If yes, when: Results:		
Have you been exposed to anyone with the above symptoms or who has had TB?		
Has the practitioner provided TB education?		
PRACTITIONER: Recommend Personal Assistant to see Physician/Additional Follow-up?		
PRACTITIONER: Recommend TB testing be performed based on the above questions.		

RESTRICTIONS IF ANY ☐ **NONE**

PERSONAL ASSISTANT: I CERTIFY THAT I AM FREE FROM HEALTH IMPAIRMENTS WHICH POSE POTENTIAL RISK TO CONSUMERS OR PERSONNEL, OR WHICH MAY INTERFERE WITH MY PERFORMANCE OF MY DUTIES AS A PERSONAL ASSISTANT, INCLUDING HABITUATION OR ADDICTION TO DRUGS, ALCOHOL, AND OTHER BEHAVIOR-ALTERING SUBSTANCES. I AUTHORIZE MY PHYSICIAN TO DISCLOSE TO CDC THIS HEALTH ASSESSMENT FORM AND OTHER MEDICAL INFORMATION WHICH MAY BE REASONABLY REQUIRED TO SUBSTANTIATE MY FITNESS TO PERFORM THE DUTIES OF A PERSONAL ASSISTANT. I ALSO AUTHORIZE CDC TO DISCLOSE TO MY ASSESSING PRACTITIONER ANY DOCUMENTATION CONTAINED IN MY HEALTH ASSESSMENT FILE THAT IS REQUESTED IN WRITING BY ME OR BY MY ASSESSING PRACTITIONER IN CONNECTION WITH THE ASSESSMENT OF MY FITNESS TO PERFORM THE DUTIES OF A PERSONAL ASSISTANT.

PERSONAL ASSISTANT SIGNATURE: _____

PRACTITIONER'S ASSESSMENT: BASED UPON THE ASSESSMENT CONDUCTED ON THIS DATE, IT IS MY OPINION THAT, EXCEPT AS OTHERWISE NOTED HEREIN, THE INDIVIDUAL IS FREE OF HEALTH IMPAIRMENTS WHICH ARE OF POTENTIAL RISK TO CONSUMERS OR OTHER PERSONNEL OR WHICH MAY INTERFERE WITH THE PERFORMANCE OF HIS OR HER DUTIES, INCLUDING HABITUATION OR ADDICTION TO DRUGS, ALCOHOL, AND OTHER BEHAVIOR-ALTERING SUBSTANCES.

NAME_____ DATE OF ASSESSMENT _____

ADDRESS_____PHONE _____

PRACTITIONER'S SIGNATURE AND TITLE _____

Please fax form with supporting documentation to Consumer Directed Choices IMMEDIATELY to 518-690-7153.