PHYSICAL EXAMINATION Name ____

PHYSICAL DEMANDS OF JOB/WORKING CONDITIONS

Sedentary (sitting) ________________________ Outside work ____________________________

Standing ____________________________ Exposure to Fumes, Gases, Etc.__________________

Mechanical ____________________________ Climbing Ladders ____________________________

Walking ____________________________ Lifting Under 40 lbs. __________________________

Climbing Stairs ___________________________ Lifting Over 40 lbs. ___________________________

Height ____________ Weight ______________ Build: ________Slender ________Medium _______ Obese

Pulse ____________ Blood Pressure __________ Temperature ___________ Chest X-Ray ______________

Tuberculosis Skin Tests (Use Form)

VISION

With Glasses Far R ______ L ______ Near R ______ L ______ Color Vision _________

Without Glasses Far R ______ L______ Near R ______ L ______ Peripheral Vision _________

Depth Perception _________

HEARING

R ______ L ______

PHYSICAL EVALUATION

Check (✓) if normal. Enter 0 if deviation from normal and note details in space provided below.

Skin Scars	______	Superficial Glands	______	Vessels	______
Head/Neck	______	Thyroid	______	Abdomen	______
Nose/Sinuses	______	Eyes/Ears	______	Joints	______
Mouth/Throat	______	Chest	______	Extremities	______
Teeth/Gums	______	Lungs	______	Reflexes	______
Genital/Urinary	______	Hernia	______	Varicosities	______
Breasts	______	Heart	______		

SPINE

	Visual Exam	Palpation	Motion Studies
Cervical	______	______	______
Thoracic	______	______	______
Lumber	______	______	______

Psychological Status: ____

Lifting Restrictions Yes No If yes, explain:

To my best knowledge this individual is free of any communicable diseases Yes No

Notes on Abnormal Findings:

Note: Any Work Limitations:

The applicant has been advised of findings ______ Yes ______No

The applicant has been referred to his/her personal physician ______Yes ______No

Date: ______________ Signature/Examining Physician ____

Medical History Questionnaire

Name:______________________________ Telephone #: ______________
Address: ______________________________ Birth Date: ______________
______________________________ Sex: _____ M _____ F
Personal Physician: ______________________________ Telephone #: ______________
Address: ______________________________
Contact in Emergency: ______________________________ Telephone #: ______________
Allergies: ______________________________

Family History:

A. Has anyone in your family ever had?

	Yes or No	If Yes, Explain:
Stroke	_____	______________
Cancer	_____	______________
High Blood Pressure	_____	______________
Tuberculosis	_____	______________
Diabetes	_____	______________
Heart Attack	_____	______________
Bleeding Tendency	_____	______________

B. Have you ever:

	Yes or No	If Yes, Explain:
Been operated on	_____	______________
Been advised to have an operation	_____	______________
Been seriously injured	_____	______________
Been refused employment for health reasons	_____	______________
Been refused insurance for health reasons	_____	______________
Been refused for military service for health reasons	_____	______________
Received Worker's Compensation	_____	______________
Had a back injury	_____	______________
Had back trouble/back pain	_____	______________
Had a hernia or rupture	_____	______________
Had a head injury	_____	______________
Had convulsions	_____	______________

C. Have you ever had:

	Yes or No		Yes or No		Yes or No
Diabetes	_____	Varicose Veins	_____	Swelling Legs/Ankles	_____
High Blood Pressure	_____	Hemorrhoids	_____	Urination Difficulties	_____
Tuberculosis	_____	Asthma	_____	Venereal Disease	_____
Nervous Breakdown	_____	Blood in Urine	_____	Eye Conditions	_____
Heart Trouble	_____	Frequent/Chronic Cough	_____	Loss of Hearing	_____
Cancer	_____	Fainting Spells/Dizziness	_____	Measles/Rubella	_____
Arthritis	_____	Hay Fever	_____	Recent/Frequent Diarrhea	_____
Epilepsy	_____	Jaundice	_____	Anemia	_____
Hepatitis	_____	Joint Pain	_____	Mumps	_____
Rheumatic Fever	_____	Paralysis	_____	Chicken Pox	_____
Skin Rashes/ Edema	_____	Wear Glasses/Contacts	_____	Shortness of Breath	_____
Stomach Ulcer	_____	Frequent Headaches	_____	Use of Hearing Aid	_____
Take Medicine Regularly	_____				

List Current Medications: ______________________________
Explanation of Yes Answers: ______________________________
____

D. Immunizations (Give Dates)

(3) Diphtheria ______________ Mumps __________ Rubella __________ Chicken Pox __________
(3) Polio ______________ Tetanus __________ Measles __________ Tuberculosis __________
(3) Hepatitis B ______________ Small Pox__________

Women: Date of Last Menstrual Period: ______________

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY MISSTATEMENT OF FACT MAY BE GROUNDS FOR RELEASE.

Date:______________ Signature or Applicant: ______________________________