PRE-EMPLOYMENT PHYSICAL

Patient Name _____ Date of Birth _____

Please Circle: **Gender** Male Female **Marital Status:** Single Married Divorced Widowed

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Language _____ Ethnicity _____ Race _____

Email Address _____

REVIEW OF SYSTEMS

Do you have any of the following?	Yes	No		Yes	
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest Pain or tightness		
Headaches			Indigestion / Heartburn		
Difficulty with vision / Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea / Constipation		
Seasonal allergies			Irregular periods		
Sinus problems			Kidney Stones		
Tiredness or falling asleep during the day			Back pain		
Unable to tolerate heat or cold			Joint pain or swelling		
Shortness of breath with or without exertion			History of broken bones		
Sneezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		
Allergies			High Blood Pressure		
Carpal Tunnel Syndrome			Diabetes		
Loss of memory			Depression, Anxiety		
History of Tuberculosis					

Last Tetanus Shot: _____ Hepatitis B Vaccination: Yes No If Yes, when? _____

Do you Smoke? Yes No If Yes, what do you smoke? _____ How many per day? _____

Do you drink Alcohol? Yes No If Yes, what do you drink? _____ How much do you drink? _____

Do you use illicit/illegal drugs? Yes No _____

Current Medical Conditions (Please list those that you are currently receiving treatment for. Date of onset, month and year)

_____

_____

_____

Do you have allergies to any medications or other substances? Yes No If yes, please specify: _____

_____

_____

_____

-continued-

Name:_____ MR#_____

Please list prescribed medications and over the counter medications that you take:_____

_____

_____

_____

Have you ever lost time from work in the past year for any reason? Yes No If yes, please explain:_____

_____

Are you currently under the treatment or care of a physician or other health care provider? _____

_____

Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to preform your job? Yes____ No____ If yes, explain:_____

_____

PHYSICAL EXAMINATION

PATIENT NAME: _____ DATE:_____ MR# _____

VITAL SIGNS

BP _____ HR _____ SpO2 _____ TEMP _____ HEIGHT _____ WEIGHT _____

VISION: Uncorrected / Corrected: Right Eye: _____ /_____ Left Eye: _____ /_____ Both Eyes: _____ /_____

	NORMAL	ABNORMAL FINDINGS
HENNT:	_____	_____
NECK:	_____	_____
CHEST/LUNGS:	_____	_____
HEART:	_____	_____
ABDOMEN:	_____	_____
MUSCULOSKELETAL:	_____	_____
NEUROLOGICAL:	_____	_____
SKIN:	_____	_____

OTHER: _____

_____

_____

LIFT TEST: Weight_____ lbs _____

DRUG SCREEN RESULTS: _____

ASSESSMENT: _____

_____

_____

_____

Cleared without limitation: _____

Cleared with restrictions: _____

Cleared after completing evaluation: _____

Referred to: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

Print Name _____ DATE:_____