PHYSICAL EVALUATION

Personal Information (please print)

NAME _____ **Sex: M** ___ **F**___ **Date of Birth** _____

Social Security Number: _____-_____-_____

Address _____ **City** _____ **Zip** _____

Home phone: _____ **Cell phone:** _____ **Work:** _____

Emergency Contact: _____ **Phone:** _____

MEDICAL HISTORY (Answer all questions by checking "Yes "or "No")

1. Any medical problems since your Last Physical?..... ___YES ___ NO
2. Have you ever been Hospitalized?..... ___ YES ___ NO
3. Have you ever had Surgery?..... ___ YES ___ NO
4. Are you presently taking any Medications or Pills?..... ___ YES ___ NO
5. Any Allergies (medicine, bees or other stinging insects?)..... ___ YES ___ NO
6. Have you ever had High Blood Pressure?..... ___ YES ___ NO
7. Have you ever been told you have a Heart Murmur?..... ___ YES ___NO
8. Have you ever had Heart racing or skipping beats?..... ___ YES ___ NO
9. Any family members died of Heart problems or Sudden Death?..... ___ YES ___ NO
10. Any Skin problems (itching, rashes, acne?)..... ___ YES ___ NO
11. Any problems with Eyes or Vision? ..... ___ YES ___ NO
12. Have you ever sprained/strained/dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ..... ___ YES ___ NO ___ YES ___ NO
13. Have you had any other medical problems? ___ YES ___ NO
14. LAST TETANUS SHOT? _____

EXPLAIN "YES" ANSWERS_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of Patient: _____ **Date** _____

PHYSICAL EXAMINATION

NAME: _____ AGE: _____ DATE OF BIRTH: __/__/____

HEIGHT: _____ WEIGHT: _____ BP _____/_____ PULSE: _____

VISION R 20/_____ L 20/_____ CORRECTED: ___Y ___N PUPILS: _____

	NORMAL	ABNORMAL FINDINGS
CARDIOPULMONARY	_____	_____
PULSE	_____	_____
LUNGS	_____	_____
HEART	_____	_____
SKIN	_____	_____
NECK	_____	_____
SHOULDER	_____	_____
ELBOW	_____	_____
WRIST	_____	_____
HAND	_____	_____
BACK	_____	_____
OTHER	_____	

NAME OF PHYSICIAN _____ DATE: _____

ADDRESS: _____ PHONE: _____

SIGNATURE OF PHYSICIAN: _____

PHYSICAL EXAM RESULTS

***TO THE PHYSICIAN*: This employee should be free of medical conditions that would interfere with his/her ability to safely perform the activities of his/her position.**

NAME: _____ ***DATE:***_____

_____ **Medically suitable to perform his/her job duties.**

_____ **Medically unsuitable to perform the essential job functions of his/her position.**

COMMENTS: _____

_____

Name of Medical Practice or Facility _____

Address_____ **Phone #**_____

Signature of Examiner_____ **Date**_____