Medical Examination Form

Date:________________

Name: Last	First	Middle Initial	Social Security Number
Date of Birth: (month, day, year)		Age:	Sex:
Employer		Start Date:	Job Title:

Section I. Patient assessment Tool –

Person completing form:

Self Spouse/Significant other RN Other: ________________

What is the best way for you to learn new things:

Reading/Written Demonstration Listening/Verbal Other: ________________

Do you have any religious or cultural values that we should be aware of as we provide your care? Yes No

If yes, explain: ________________

Section II. Occupational History –

Have you had any work-related injuries or illnesses leading to time off work or work restrictions? Yes No

If yes, list types of injuries and outcomes: ________________

Do you currently have any activity or work restrictions advised by a healthcare provider? Yes No

If yes, please list restrictions: ________________

Have you experienced any known or suspected adverse health effects due to workplace exposures? Yes No

If yes, please list exposures and health effects: ________________

Have you been a participant in any OSHA surveillance programs? Yes No

If yes, circle type: Hearing (Noise) Respirator Hazmat Arsenic Cadmium Lead Chromium Formaldehyde Other: ________________

Section III . Injury History –

Have you ever been seriously hurt in a motor vehicle accident, and required medical attention? Yes No

If yes, list year and outcome of injuries: ________________

Have you ever had a head injury or concussion? Yes No

If yes, list any symptoms you still have? ________________

Section III continued on page 2 (turn to next page)

Name: ______________________ **Date of Birth:** ______________

Have you ever had a neck or back injury that required more than one visit with a health care provider? Yes No

If yes, list year and type of treatment: ______________________

Have you ever been diagnosed with carpal or cubital tunnel syndromes? Yes No

If yes, list year and type of treatment: ______________________

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Have you had any injuries of the following joints that required more than one visit with a health care provider?

Shoulders Yes No If yes, describe injury and treatment: ______________________

Elbows Yes No If yes, describe injury and treatment: ______________________

Hands/Wrists Yes No If yes, describe injury and treatment: ______________________

Hips Yes No If yes, describe injury and treatment: ______________________

Knees Yes No If yes, describe injury and treatment: ______________________

Ankles/Feet Yes No If yes, describe injury and treatment: ______________________

Pinched Nerve Yes No If yes, describe injury and treatment: ______________________

Section IV. Medical History —

Have you been diagnosed with and/or required treatment for any of the conditions listed below? Explain all yes answers below.

	Yes	No		Yes	No		Yes	No
Migraines			Chest Pain			Prostate Disease (males)		
Fainting			Leg Cramps			Gynecological Problems (females)		
Seizures			High Blood Pressure			Burns		
Stroke			Varicose Veins			Eczema		
Depression			Shortness of Breath Limiting Activity			Rheumatoid Arthritis or Lupus		
Panic Attacks or Anxiety Requiring Treatment			Bronchitis or COPD			Gout		
Mental Illness			Asthma			Anemia		
Vision Loss			Ulcers			Lymphoma		
Hearing Loss			GERD (reflux)			Cancer		
Thyroid Problems			Hernia			Sleep Apnea		
Diabetes			Liver Disease, Hepatitis			Alcoholism		
Heart Disease			Gall Bladder Disease			Drug Dependence/ Addiction		
Heart Attack			Disorders of Genitals			Persistent Numbness/Tingling of Hands or Feet		
Irregular Heartbeat			Kidney Disease			Other conditions requiring medical attention, but not listed.		

Explanations of "yes" answers: ______________________

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Name: ______________________ **Date of Birth:** ______________

Allergies: Medication Yes No List: ______________________
Environmental Yes No List: ______________________
Latex Yes No

Medications:

List current prescription medications: ______________________

List current over the counter medications: ______________________

List current herbal or nutritional supplements ______________________

Surgery and Procedures:

List any surgeries you have had: ______________________

List any injection treatments (epidural, joint, trigger point): ______________________

List cardiac procedures you have had (angioplasty, stents, cardiac catheterization/angiography): ______________________

FEMALES ONLY

Date of last period: ______________________ Are you pregnant? Yes No

I, THE UNDERSIGNED, DO HEREBY CERTIFY THE ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT. I UNDERSTAND THAT THIS IS A CONFIDENTIAL DOCUMENT AND THAT FALSIFICATION, MISREPRESENTATION, OR OMISSION OF INFORMATION MAY RESULT IN DISCHARGE REGARDLESS OF WHEN DISCERNED.

Employee Signature ______________________ **Date:** ______________

Reviewed: Date ______________________ **Initials:** ______________

Name: ______________________ Date of Birth: ______________

Section V. Assessment

VITAL SIGNS					
Height	Weight	BP	Temp	Pulse	Respirations

VISION TESTING					
Vision Screener:	Snellen	Titmus			
Wearing Contacts:	Yes	No	Wearing Glasses:	Yes	No

	Far	Near			
Both Eyes	20/		Color		
Right Eye	20/		Ishihara	# Correct	Total
Left Eye	20/				
Stereo depth	Satisfactory:		Unsatisfactory:		

Peripheral Left Temporal:	(Circle)	85°	75°	55°	Nasal 45°	Failed
Peripheral Right Temporal:	(Circle)	85°	75°	55°	Nasal 45°	Failed
Other:						

Clinical Staff Signature ______________________

PHYSICAL EXAMINATION

Check N if normal, AB if abnormal, NE if not examined

	N	AB	NE		N	AB	NE		N	AB	NE
General Appearance				Lungs				Neck (ROM)			
Skin				Heart				Thoracic - Lumbar Spine			
Eyes				Peripheral Pulses				Shoulders			
Ears				Varicose Veins				Elbows			
Nose				Abdomen				Hands - Wrists			
Oropharynx				Hernia				Hips			
Thyroid				Neurological				Knees			
Cervical Nodes				Gait				Ankles - Feet			

Comments on abnormal findings: ______________________

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Areas Examined but not listed above: ______________________

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Physician's Note on History: ______________________

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MEDICAL DISPOSITION -SEE FORM

Recommend without restrictions for: ______________________

Recommend with the following restriction(s)/limitation(s): ______________________

Decision deferred. re-evaluate: ______________________

Not recommended for placement: ______________________

Recommend follow-up with family physician: ______________________

On hold (Specify reason): ______________________

Provider Signature: ______________________ **Date:** ______________