

# PHYSICAL EXAMINATION



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Child Exam      Name: \_\_\_\_\_ Gender:   M     F    
 Adult Exam      Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Pre-Employment\*      Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Workers Comp\*      City/State/Zip: \_\_\_\_\_ Private Physician: \_\_\_\_\_

\*Name of Company \_\_\_\_\_

PLEASE MARK YES OR NO IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

	YES	NO		YES	NO		YES	NO
1. Allergies	___	___	22. Ganglion Cyst	___	___	43. Pinched nerves	___	___
2. Anemia	___	___	23. Hay Fever	___	___	44. Pneumonia	___	___
3. Ankle swelling	___	___	24. Head Injury	___	___	45. Pregnant	___	___
4. Arthritis	___	___	25. Heart trouble	___	___	46. Rectal bleeding	___	___
5. Asthma	___	___	26. Hernias	___	___	47. Rheumatic fever	___	___
6. Back injury	___	___	27. High blood pressure	___	___	48. Rheumatism	___	___
7. Back Pain	___	___	28. Hospitalization	___	___	49. Rotor cuff injury	___	___
8. Bladder problems	___	___	29. Infectious disease	___	___	50. Sciatica	___	___
9. Bursitis	___	___	30. Jaundice	___	___	51. Severe headaches	___	___
10. Cancer	___	___	31. Kidney trouble	___	___	52. Shortness of breath	___	___
11. Carpal tunnel syndrome	___	___	32. Knee injury	___	___	53. Shoulder Injury	___	___
12. Chiropractic treatment	___	___	33. Liver disease	___	___	54. Sinus Trouble	___	___
13. Chronic cough	___	___	34. Loss of consciousness	___	___	55. Skin condition	___	___
14. Convulsions	___	___	35. Lung disease	___	___	56. Stomach trouble	___	___
15. Diabetes	___	___	36. Menstrual problems	___	___	57. Surgery	___	___
16. Do you smoke?	___	___	37. Neck injury	___	___	58. Tendency to bleed	___	___
17. Eczema	___	___	38. Nervous disorder	___	___	59. Tendonitis	___	___
18. Epilepsy	___	___	39. Neuritis	___	___	60. Tumors/Cysts	___	___
19. Fainting	___	___	40. Neurologic conditions	___	___	61. Ulcers	___	___
20. Fractured/Broken bone	___	___	41. Numbness arms/legs	___	___	62. Varicose veins	___	___
21. Gall Bladder	___	___	42. Ovary/Womb disease	___	___	63.	___	___

Please explain briefly any answers marked YES giving dates, and any surgery hospitalizations, or if it currently continues as a problem.

\_\_\_\_\_

Current or on-going back problems? \_\_\_\_\_ If yes, is it aggravated by, Light lifting (0-15 lbs.)? \_\_\_\_\_ Medium Lifting (15-50 lbs.)? \_\_\_\_\_  
 Heavy Lifting (greater than 50 lbs.)? \_\_\_\_\_ Bending or Twisting? \_\_\_\_\_ Prolonged standing? \_\_\_\_\_ Other? \_\_\_\_\_

Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Currently under a Doctor's care? \_\_\_\_\_ For What? \_\_\_\_\_

Pregnant? \_\_\_\_\_ Do you suffer from any disability? \_\_\_\_\_

Please list any previous jobs you have held over one year and if exposed to any potentially harmful exposures (e.g. chemicals, radiation, dusts, loud noises, or exposure to cold temperatures, etc.)

JOB	NUMBER OF YEARS	EXPOSURES
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I CERTIFY THAT I HAVE PROVIDED ACCURATE AND COMPLETE INFORMATION REGARDING MY HEALTH AND THAT ANY MISREPRESENTATION OR MATERIAL OMITTED MAY BE CAUSE FOR DISMISSAL.

APPLICANT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

I GRANT PERMISSION TO THE URGENCY ROOM TO RELEASE INFORMATION PERTINENT TO THE JOB FOR WHICH I AM BEIGN CONSIDERED.

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## PHYSICAL EXAMINATION\*

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Last TB: \_\_\_\_\_ Last Tetanus: \_\_\_\_\_ Hep. B. Vacc.: \_\_\_\_\_

Position Applied For: \_\_\_\_\_

	NL	ABNL	(EXPLAIN)		NL	ABNL	(EXPLAIN)
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>		8. Extremities/M-S	<input type="checkbox"/>	<input type="checkbox"/>	
2. Eyes (R) 20/ (L) 20/ (B) 20/ Color Test	<input type="checkbox"/>	<input type="checkbox"/>		9. Spine	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
3. Head/ENT	<input type="checkbox"/>	<input type="checkbox"/>					
4. Chest/Lungs	<input type="checkbox"/>	<input type="checkbox"/>		10. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	
5. Hernia Exam (males only)	<input type="checkbox"/>	<input type="checkbox"/>		11. Neck	<input type="checkbox"/>	<input type="checkbox"/>	
6. C-V Pulse _____ BP _____	<input type="checkbox"/>	<input type="checkbox"/>		12. Tinel's R	<input type="checkbox"/>	<input type="checkbox"/>	
				L	<input type="checkbox"/>	<input type="checkbox"/>	
7. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>		13. Phalen's R	<input type="checkbox"/>	<input type="checkbox"/>	
				L	<input type="checkbox"/>	<input type="checkbox"/>	

\*Findings may represent only those relevant to placement.

Drug Screen Results: \_\_\_\_\_

Lab Results: \_\_\_\_\_

Other Results: \_\_\_\_\_

### GUIDELINES FOR PLACEMENT - PRE-EMPLOYMENT OR WORKER'S COMP EMAM

- Able to safely perform the essential functions of the position.
- Free to overt communicable disease.
- Unable to safely perform the essential functions of the position.
- Able to safely perform the essential functions of the position, with the accommodations below:

Lifting: \_\_\_\_\_  No Lifting greater than \_\_\_\_\_ pounds.

Motion: \_\_\_\_\_  Avoid repetitive motion of \_\_\_\_\_

Medical: \_\_\_\_\_

Safety Consideration: \_\_\_\_\_

Assignment Alteration: \_\_\_\_\_

Requested by applicant if covered by ADA: \_\_\_\_\_

Further studies indicated: \_\_\_\_\_

Additional Documentation requested: \_\_\_\_\_

Applicant advised to see personal physician

Notes/Recommendations: \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

**NOTICE TO EMPLOYERS:** The following are guidelines pertaining to the physical examination of the applicant. The Urgency Room's understanding as to "essential functions" is based upon information received from you. The following is not to be interpreted as our conclusion that certain job tasks are/are not "essential functions." The following guidelines are based upon reasoned medical judgment and are not intended to assure compliance with the Americans with Disabilities Act (ADA) and/or to substitute for you case-by-case review of obligations arising under the ADA (including but not limited to determination as to essential functions, reasonable accommodation and the existence of a "direct threat").