Your Hospital's Logo Here

PHYSICAL EXAMINATION

PATIENT IDENTIFICATION

AGE:	SEX: ☐ Male ☐ Female	HEIGHT:	WEIGHT:	TEMP:	BP:	PULSE (SIT):

DRUG ALLERGIES:

VISION: R 20 / ..... L 20 / ..... Corrected ? ☐ Yes ☐ No

	NEG	POS	(**Explain positive findings.**)
3. NECK / HEAD	☐	☐	
4. E.E.N.T.	☐	☐	
5. HEART	☐	☐	
6. LUNGS	☐	☐	
7. BREASTS	☐	☐	
8. ABDOMEN	☐	☐	
9. RECTAL	☐	☐	
10. GENITALIA	☐	☐	
11. MUSCULOSKELETAL	☐	☐	
12. EXTREMITIES	☐	☐	
13. VASCULAR-PULSES	☐	☐	
14. NEUROLOGICAL	☐	☐	
15. SKIN	☐	☐	
16. LYMPHATICS	☐	☐	

ASSESSMENT / DIAGNOSIS:

PLAN:

CLINICIAN SIGNATURE / TITLE:	DATE:	PHYSICIAN SIGNATURE: M.D.	DATE:

PART OF THE MEDICAL RECORD

MEDICAL HISTORY FORM

Pre-Employment: _____ Annual: _____ Men / Women's Assessment: _____ Injury: _____

NAME:		
ADDRESS:		
SOCIAL SECURITY #:	DATE OF BIRTH:	PLACE OF BIRTH:
TEL # (HOME):	TEL # (WORK):	
EMPLOYER:	OCCUPATION:	
PHYSICIAN:	PHYSICIAN TEL #:	
DATE OF LAST DOCTOR'S OFFICE VISIT:	REASON:	
CURRENT MEDICAL PROBLEMS:		
CURRENT MEDICATIONS:		
MEDICATION ALLERGIES:		
ENVIRONMENTAL ALLERGIES:	LATEX:	SEASONAL ALLERGIES:
OTHER ALLERGIES:		

HAVE YOU EVER HAD / OR NOW HAVE

☐ HEART TROUBLE ☐ TUBERCULOSIS ☐ STOMACH / ULCER ☐ PSYCHIATRIC TREATMENT
☐ SURGERY ☐ AUTO ACCIDENT ☐ BACK INJURY ☐ FREQUENT HEADACHES
☐ HOSPITALIZATION ☐ NEEDLESTICK INJURY ☐ ORTHER ORTHOPEDIC PROBLEM ☐ ASTHMA
☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ DERMATITIS / SKIN TROUBLE
☐ WORK RELATED INJURY (If checked, did you receive WORKER'S COMPENSATION? ___ YES ___ NO)

LIFESTYLE

HAVE YOU TRAVELED OUTSIDE THE USA IN THE PAST (1) YEAR? ☐ YES ☐ NO IF "YES", WHERE? _____

DO YOU SMOKE CIGARETTES? ☐ YES ☐ NO IF "YES", HOW MUCH? ☐ < 5 CIGARETTES / DAY ☐ 6 - 10 CIGARETTES / DAY ☐ 11 - 20 CIGARETTES / DAY ☐ > 20 CIGARETTES / DAY

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF "YES", HOW MUCH? _____ Per Week.

DO YOU USE OTHER RECREATIONAL DRUGS? ☐ YES ☐ NO IF "YES", WHAT TYPE? _____

DO YOU REGULARLY EXERCISE? ☐ YES ☐ NO IF "YES", HOW OFTEN (WEEKLY) ? ☐ 1 - 3 ☐ 4 - 5 ☐ > 6

TYPE OF EXERCISE: _____

IMMUNIZATIONS

	DATE	DATE OF LAST	
☐ BCG VACCINE	_____	_____	DENTAL EXAM
☐ TD VACCINE	_____	_____	EYE EXAM
☐ MMR VACCINE	_____	_____	PPD TEST ☐ POSITIVE ☐ NEGATIVE
☐ HEPATITIS B	_____		EVER TREATED FOR TB? ☐ YES ☐ NO

WOMEN ONLY

LAST MENSTRUAL PERIOD:	LAST PAP SMEAR:	LAST PAP SMEAR:
	RESULTS:	RESULTS:

MEN ONLY

LAST RECTAL / PROSTATE EXAM:	LAST PSA:
RESULTS:	RESULTS:

I GIVE MY CONSENT FOR A PHYSICAL EXAMINATION THAT MY INCLUDE SUCH TESTS / PROCEDURES AS DEEMED NECESSARY.

NAME (Printed): _____ SIGNATURE: _____ DATE: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____ NAME: _____ DAYTIME TEL #

PART OF THE MEDICAL RECORD