HARDIN COUNTY GENERAL HOSPITAL
Rosiclare, IL 62982

EMPLOYEE PHYSICAL EXAMINATION

Name: _____ D.O.B. _____ Date: _____

Position Applied For: _____ Phone #: _____

1. Have you ever had or now have:

A. Respiratory	Y	N	D. Neurological	Y	N
Asthma			Convulsions		
Hay Fever			Epilepsy		
Sinus Problems			Paralysis		
Tonsillitis			Numbness of hands or feet		
Bronchitis			Double Vision		
Pleurisy			Severe Headaches		
Pneumonia			Dizzy Spells		
Shortness of Breath			Emotional Disorders		
Tightness / Discomfort of Chest			**E. Genitourinary**		
Tuberculosis			Blood in Urine		
Emphysema			Kidney Problems		
Chronic Cough			Urination Difficulty		
B. Cardiovascular			Bladder Problems		
High Blood Pressure			Sexually Transmitted Disease		
Heart Problems			**F. Endocrinological**		
Swelling of Ankles			Diabetes		
Fainting Spells			Thyroid Problems		
Varicose Veins			Cancer		
Blood Clots			**G. Musculoskeletal**		
Anemia			Back Aches or Injury		
Rheumatic Fever			Back Surgery		
C. Gastrointestinal			Pain on Lifting		
Stomach Ulcer			Chiropractor Treatments		
Frequent Nausea or Indigestion			Knee Surgery		
Frequent Bowel Problems			Swollen Joints		
1. Constipation			Bursitis		
2. Diarrhea			Arthritis or Rheumatism		
Hernia			Bone Fracture		
Liver Problems			Limited Movement: _____		
Hepatitis			Pain/Tingling of Wrist		
Jaundice			**H. Allergies:**		
Gall Bladder Problems					

Provide special medical history for any condition indicated with a "Y" answer:

_____

_____

2. **List injuries, surgeries, or serious illnesses:**

TYPE	DATE	RESULT / COMPLICATIONS	BY WHOM TREATED

3. Do you have any physical complaints or disabilities at present? ☐ Y ☐ N If yes, explain:

_____

_____

4. Are you taking any medication now? ☐ Y ☐ N If yes, please list them:

_____

_____

IMMUNIZATIONS / TESTS	DATE LAST RECEIVED	CHILDHOOD DISEASES	YES	NO
Tetanus Toxoid		**Chicken Pox**		
Tetanus / Diphtheria		**Rubeola**		
Basic DPT & Polio		**Rubella**		
Rubella Vaccine		**Mumps**		
Measles Vaccine		**Scarlet Fever**		
Mumps Vaccine		**Whooping Cough**		
TB skin test	**result**			
Hepatitis B Vaccine				

I, the undersigned, do hereby certify that the answer's to the above questions are true and give permission for this examination. I authorize Hardin County General Hospital to provide these services. I also authorize the release of the results to Hardin County General Hospital and I understand that false statements will subject me to immediate discharge.

Employee Signature: _____ Date: _____

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Resp: _____

VISION TEST	(R) EYE	(L) EYE	Required LAB / X-RAY
Distant vision without correction			**CBC ☐ Normal**
" " with correction			**URINE DRUG SCREEN ☐ Normal**
Near Vision without correction			**CXR ☐ Normal**
" " with correction			**L/S SPINE X-RAY ☐ Normal**
Color vision			

Normal	CLINICAL EVALUATION	Abnormal
	Head, Face, Neck, Scalp	
	Nose	
	Mouth/Throat	
	Ears	
	Eyes	
	Lung/Chest	
	Heart	
	Vascular Systems (varicosities)	
	Abdomen	
	Hernia	
	Endocrine System	
	GU System	
	Extremities (strength/ROM)	
	Spine (mobility/deformity)	
	Skin (lymphotics/rash)	
	Neurological (reflexes)	

Physician Summary: Employee fit for work? ☐ Y ☐ N Restrictions? ☐ None

_____

_____

_____

Physician Signature: _____ Date: _____