PRE-EMPLOYMENT PHYSICAL EXAMINATION FORM

Name: _____ **Date:** _____

Date of Birth: _____ **SSN:** _____

Address: _____

Job Title: _____

Height: **Weight:**

T: **P:** **B/P:** **RR:** **Sp02**

Smoker: **Y / N ?**

Health History:

DOES THE PATIENT HAVE:?	YES	NO
Chronic or Recurrent Illness		
Head/Brain Injuries		
Seizures/Epilepsy		
Concussion		
Dizziness or frequent headaches		
Eye disorders or impaired vision		
Ear disorders or hearing loss		
Cardiovascular condition		
High blood pressure		
Lung disease/ Asthma		
Diabetes or elevated blood sugar		
Muscular Disease		
Joint or back injuries		
Broken bones or dislocation		
Shortness of Breath with exercise		

For any "Yes", indicate the date, treatment, and current status of the condition:

_____

_____

Is the patient capable of performing the necessary duties of work, including: standing for long periods of time (8+ hours) and pushing/pulling/lifting 50+ lbs? circle Yes or No

Is the patient free of communicable disease? circle Yes or No

_____

Signature of Examiner:_____ Date:_____