High Point Occupational Healthcare Services

FIT FOR DUTY EXAM/HEALTH HISTORY

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_SEX\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOCIAL SECURITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAMILY PHYSICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please read carefully and answer all by *CIRCLING* (Y) for Yes or (N) for No. Give details (describe when and how) for all “Yes” answers in the space provided at the bottom of the page.**

**DO YOU HAVE OR HAVE YOU EVER HAD:**  **HAVE YOU EVER?**

1. Heart trouble or high blood pressure? \_\_Y \_\_N 31. Had an occupational disease? \_\_Y \_\_N
2. Convulsions, epilepsy, fainting spells, dizziness? \_\_Y \_\_N 32. Worked in a dusty trade? (Yarn mfg,
3. Frequent or severe headaches? \_\_Y \_\_N Exposure to asbestos, silicon, etc.)? \_\_Y \_\_N
4. Any type of back/neck problem, or ruptured disk? \_\_Y \_\_N 33. Received workers’ compensation or
5. Any broken bones, dislocated joints? \_\_Y \_\_N Disability pension? \_\_Y \_\_N
6. Arthritis or recurring pain in the joints? \_\_Y \_\_N 34. Are you currently receiving medical
7. Tendinitis, carpal tunnel syndrome, ganglion cyst? \_\_Y \_\_N Treatment for any condition? \_\_Y \_\_N
8. Numbness or tingling in the hands and/or feet? \_\_Y \_\_N 35. Are you currently taking any medication? \_\_Y \_\_N
9. Skin disorder or eczema? \_\_Y \_\_N Please List Medications Below:
10. Varicose veins or leg sores? \_\_Y \_\_N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Asthma, shortness of breath, chest tightness or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

chronic cough? \_\_Y \_\_N

1. Tuberculosis, bronchitis, or other lung problem? \_\_Y \_\_N 36. Do you now, or have you ever smoked? \_\_Y \_\_N
2. Nervous or mental disorder? \_\_Y \_\_N # per day # of years
3. Alcohol or drug use problems? \_\_Y \_\_N Cigarettes \_\_\_\_\_packs \_\_\_\_\_\_
4. Diabetes? \_\_Y \_\_N Cigars \_\_\_\_\_\_ \_\_\_\_\_\_
5. Kidney or bladder problem? \_\_Y \_\_N Pipes \_\_\_\_\_\_ \_\_\_\_\_\_
6. Hernia? \_\_Y \_\_N
7. Cancer or tumor? \_\_Y \_\_N 37. If ex-smoker, number of years stopped \_\_\_\_\_\_\_\_\_\_\_
8. Ulcer or any problem with the stomach, intestines 38. Do you now, or have you ever used

or bowels? \_\_Y \_\_N smokeless tobacco? \_\_Y \_\_N

1. Jaundice, hepatitis? \_\_Y \_\_N 39. Date of last tetanus booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_
2. Ear infections/trouble hearing? \_\_Y \_\_N
3. Eye Problems? \_\_Y \_\_N
4. Do you wear contact lenses/glasses? \_\_Y \_\_N
5. Injuries? \_\_Y \_\_N
6. Thyroid problems/goiter? \_\_Y \_\_N
7. Hay fever, allergies, drug reactions? \_\_Y \_\_N
8. Any physical defects or deformities? \_\_Y \_\_N :
9. Significant weight loss/gain within the past year? \_\_Y \_\_N
10. Venereal disease or Sickle Cell Anemia? \_\_Y \_\_N

**Explain all “YES” answers. List number of question with explanation:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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MAJOR HOSPITALIZATIONS: If you have ever been hospitalized for any medical illness or operation, please list below (Do not include normal childbirth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and agree that misrepresentation or omission of fact on this physical examination form may be cause for cancellation of the application or separation from service of the company.

**Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAM:

Height\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pulse\_\_\_\_\_\_\_\_\_\_Respirations\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Visual Acuity: Left\_\_\_\_\_\_\_\_\_\_\_\_ Right\_\_\_\_\_\_\_\_\_\_\_\_ With/Without Glasses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Titmus/Snellen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Color Vision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Urinalysis: S. G. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Protein\_\_\_\_\_\_\_\_\_\_\_\_\_Glucose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXAMINATION: CIRCLE N (NORMAL) or A (Abnormal)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | REMARKS |  |  | REMARKS |
| SKIN-SCALP | N A |  | HERNIA | N A |  |
| EYES | N A |  | SHOULDERS/ARMS | N A |  |
| EARS | N A |  | HANDS | N A |  |
| NOSE | N A |  | LEGS/FEET | N A |  |
| THROAT | N A |  | SPINE:INSPECTION | N A |  |
| MOUTH-TEETH | N A |  | RANGE OF MOTION | N A |  |
| NECK | N A |  | REFLEXES | N A |  |
| HEART | N A |  | LYMPH NODES | N A |  |
| LUNGS | N A |  | NEUROLOGICAL | N A |  |
| CHEST | N A |  | GENITALIA | N A |  |
| BREASTS | N A |  | RECTAL | N A |  |
| ABDOMEN | N A |  |  |  |  |
|  |  |  |  |  |  |

Has the job description been reviewed to determine if the employee can return to his or her regular job duties? \_\_ Y \_\_ N

Is more testing recommended (Physical Abilities Test or CRT Return To Work Test) to determine employee’s capability to return to work? \_\_\_ Y \_\_\_ N

IMPRESSION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DISPOSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Examiner’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_