

MD PHYSICAL/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 **FOR FEMALES**
5. Any Operations? \_\_Y \_\_N
6. Injuries? \_\_Y \_\_N 1. Have you ever had any female or
7. Thyroid problems/goiter? \_\_Y \_\_N Menstrual problems? \_\_Y \_\_N
8. Hay fever, allergies, drug reactions? \_\_Y \_\_N 2. Have you had a menstrual period within
9. Any physical defects or deformities? \_\_Y \_\_N the last 30 days? \_\_Y \_\_N If No, explain:
10. Significant weight loss/gain within the past year? \_\_Y \_\_N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Venereal disease or Sickle Cell Anemia? \_\_Y \_\_N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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 |  | TINEL’S | N A |  |
|  |  |  | FINKELSTEIN | N A |  |

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

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

EXAMINER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_