

COMPREHENSIVE HISTORY/PHYSICAL EXAM FORM

PERSONAL DATA

DATE: _____

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____ Home phone: _____

Place of Birth: _____ Company: _____ Position applied for: _____

Employed previously by this Co. ☐ Yes ☐ No If Yes, indicate when _____

Whom do we notify in case of an emergency? (Name/Relationship) _____ Phone #: _____

Primary Care Physician: _____ City/State: _____

Information requested herein will not be used in any manner contrary to any law, rule or regulation and is obtained only for medical examination to ensure safe job placement in consideration of specific job demands and exposures.

A. MEDICAL HISTORY Have you ever had or have any of the following illnesses? (Yes or No)

	Yes	No		Yes	No
Chest Pain / Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Legs	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease/Asthma/Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma / Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems/ Perforated Ear Drums	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Backache / Pain	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (seizures)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems/Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headache	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Bowel Problems including Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

Please explain above Yes responses: _____

Have you ever been treated for...?	Yes	No	Explain for all Yes responses:
Drug Addiction or Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever smoked?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had or been advised to have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you allergic to any medication?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you taking any medications presently?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a recent medical examination?	<input type="checkbox"/>	<input type="checkbox"/>	

B. INJURIES

Have you ever experienced:	Yes	No		Yes	No
Bone Fracture	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremities (Shoulder/Arm/Wrist/Hand) Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Back Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremities (Leg/Knee/Foot) Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Lost Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Neck Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Car Accident with Injury	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

PATIENT NAME: _____

DOB: _____

C. OCCUPATIONAL PROFILE

Back History:	Yes	No	Explain:
1)Have you ever experienced back injury that resulted in:			
Lost time from work/school	<input type="checkbox"/>	<input type="checkbox"/>	
Visit to the doctor	<input type="checkbox"/>	<input type="checkbox"/>	
Visit to the chiropractor or physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	
2)Have you ever had:			
Back x-rays , CT Scan or MRI	<input type="checkbox"/>	<input type="checkbox"/>	

Have you ever been or are you now exposed to any of the following? Have you ever been treated for any of the following?														
	Exposed		Treated			Exposed		Treated			Exposed		Treated	
	Yes	No	Yes	No		Yes	No	Yes	No		Yes	No	Yes	No
Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Heat / Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loud Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biologic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood/Bodily Fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
										Dust or Fibers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the questions above, please provide additional details:

Dates of Employment	Job Title / Description of work / Employer	Exposures (chemicals, blood, etc...)

Have you ever received Disability or Compensation Benefits? ☐Yes ☐No If yes, indicate where and when:Have you ever lost time at work due to an injury or illness? ☐Yes ☐No If yes, explain:Have you ever been advised to change jobs or work assignments because of any health problems or injuries? ☐Yes ☐No If yes, explain: _____

List any problems that you wish to discuss with the doctor: _____

D: MEDICAL DECLARATION

I CERTIFY THAT THE FOREGOING IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE I UNDERSTAND THAT I MAY BE REQUESTED AT THE OPTION OF MY EMPLOYER TO COMPLETE A PHYSICAL EXAMINATION I AUTHORIZE ANY OF THE DOCTORS, CLINICS OR HOSPITALS MENTIONED ABOVE TO FURNISH A COMPLETE TRANSCRIPT OF MY MEDICAL RECORD FOR PURPOSE OF PROCESSING MY APPLICATION FOR THIS EMPLOYMENT, SUBJECT TO CONFIDENTIALITY STATUTES

Date: _____ Signature: _____

Reviewed by: _____ Date: _____ Time: _____