Employment Physical Exam

Patient Name:_____ Date of Birth:_____ Age:_____ □ Male □ Female
Address:_____ Phone:_____
□ Single □ Married
Department & Position Applied for:_____
Currently under the care of a Physician: □ Yes □ No If yes, for what:_____
The name of your personal Physician:_____
Are you taking medicine regularly: □ Yes □ No Please List:_____

Medical History: Please check those conditions that apply to you, and note any comments below.

□ Allergy	□ Frequent Headaches	□ Abnormal Fatigue	□ Asthma	□ Epilepsy
□ Digestive Disorders	□ Bronchitis	□ Fainting or Dizziness	□ Back Injury	□ Pneumonia
□ Diabetes	□ Broken Bones	□ Chronic Cough	□ Frequent Colds	□ Rheumatism
□ Tuberculosis	□ Anemia	□ Physical Deformities	□ Pain in Chest	□ Jaundice
□ Weight Gain or Loss	□ Heart Disease	□ Syphilis	□ Nervous Breakdown	□ Malaria
□ Shortness of Breath	□ Gonorrhea	□ Skin Condition	□ Hernia	
□ Treatment for Blood Pressure	□ Surgical Operations-Please List		□ Other serious Disease or Injury – Please List	

Comments_____
_____
Have you ever or do you currently have a back condition: □ Yes □ No If yes, explain :_____
Have you had any serious accidents: □ Yes □ No If yes, explain :_____
Are you a veteran: □ Yes □ No If yes, reason for Discharge :_____
Were you wounded: □ Yes □ No Resulting Disability :_____
Skin Trouble: □ Rashes □ Hives □ Eczema □ Hands crack or chap easily

Family History:

		State of Health	Cause of Death
Father:	Living □ Yes □ No	_____	_____
Mother:	Living □ Yes □ No	_____	_____
Siblings:	Living □ Yes □ No	_____	_____

□ Whooping Cough □ Measles □ Mumps □ Chicken Pox □ Scarlet Fever
□ Never had TB □ Never had a reaction to TB □ Last PPD:_____

Female Applicants: Please list month, date and year of your last menstruation:_____
Was it □ Regular □ Irregular or □ Painful How many pregnancies:_____ How many children:_____

Habits: Tobacco: □ Yes □ No Alcohol: □ Yes □ No Drugs: □ Yes □ No

Hospitalizations and Surgical Procedures:

Reason	Name and Address of Hospital	Date of Hospitalization

I, the undersigned, do hereby authorize the authorities of Aspire Rural Health System to request the release of my records for their information and necessary action. I certify that the above is true and complete to the best of my knowledge.

_____ _____
Applicant's Signature Date

Employment Physical Exam

Date:_____ Height:_____ Weight:_____ Temperature:_____

BP:_____ Heart:_____ Murmurs:_____ Pulse:_____

Exam

	WNL	Exception		WNL	Exception
Head			Nose		
Ears			Speech		
Mouth			Lung Sounds		
Neck			Abdomen		
Pupils			Skin		
Vision			Spine		
Hearing			Upper Ext		
Teeth			Lower Ext		
Glands			Neuro Check		
Tonsils			Mental Reaction		

OTHER FINDINGS AND REMARKS:

_____

_____

_____

_____

_____

Based on the physical examination I have administered on this applicant, it is my opinion that this person

☐ is physically capable **☐ is incapable**

of assuming all the job responsibilities with no restrictions. This opinion is subject to final x-ray and laboratory results.

Signature:_____ Date:_____