

SECTION 1 – To be completed prior to medical appointment

Name: _____

Date of Exam: _____

Social Security Number (last four digits) _____

Allergies				
Immunizations List approximate date	Tetanus Yes No	Hepatitis B Yes No	Ruebella Yes No	Mumps Yes No
	Date	Date	Date	Date
Social History	Tobacco User Yes No	Alcohol User Yes No	Drug Usage Yes No	
Current Medications/Dosage/Duration of Use				
Current Medications/Dosage/Duration of Use				
List any serious illness or traumatic injury/hospitalization/surgery, etc.				
Have you had any respiratory conditions or symptoms? (Asthma, shortness of breath, wheezing, chronic cough, etc.)				
Have you had any cardiovascular symptoms? (high blood pressure, chest pain, murmurs, palpitations, dizziness, etc.)				
Have you had any join/muscle pain or swelling? Neck/Back problems?				
Have you experienced headaches, fatigue, dizziness, fainting, seizures?				
Do you have any mental or emotional disorders that you wish to inform us about, either currently or in the past?				
Are you diabetic?				
Applicant's Signature		Date		

SECTION 2 – Physical Examination ~ To be completed by applicant’s physician

Name: _____

Date of Exam: _____

Social Security Number (last four digits) _____

General description of the patient: (Include nutritional status, personal hygiene and noticeable aspects of personal appearance.)					
Vital Signs	Pulse Rate	Regular or Irregular	Temperature	Height	Weight
	Blood Pressure Systolic _____ Diastolic _____			Respiratory Condition	
Comment on the following					
Eyes					
Ears					
Nose/Throat					
Neck					
Lungs					
Heart					
Abdomen					
Spine					
Extremities/Joints					
Neurologic					
Mantoux Test	Date	Results	Xray Date	Results	
Is applicant diabetic:	Yes No	Insulin Dependent	Yes	No	
Is applicant free of communicable disease			Yes	No	
Ongoing medical problems:					
Is applicant medically qualified to work in his/her job title?			Yes No	Comments:	
Physician’s Signature			Date		
Physician’s Name/Address/Telephone Number					