Employee Health Medical Record

Name:		Date:
Address:	City:	State, Zip:
Phone (Home/Cell):	(work):	Sex: F M
Email Address:		DOB:
Date of Last Physical:	Family Doctor	
Address of Family Doctor:		
Family History: (Circle) Heart Disease Cancer Diabetes Stroke		
Dominate Hand: (Circle) Left Right		

List Any Hospitalizations or surgery you have had in the past

Date	Reason

Are you currently taking any Medication? **Yes** **No** If yes, what are they:_____

_____

Do you smoke cigarettes? **Yes** **No** If yes, # of packs per day_____ / Years_____

Are you using harmful drugs? **Yes** **No**

How much alcohol do you drink? None 1-7 drinks per week 8-14 drinks per week 15+ drinks per week

How many days of work did you miss in the past 12 months due to illness or injury?_____

Have you been in the military service? Yes No Branch of service:_____

How long? _____ Assignment:_____

List any chronic health problems you may have:
Allergic Reactions: Have you ever experienced adverse reactions to any drug, food or chemical? If so, please describe reaction:

Job Applied for:
Describe your current job:

Please check if you have or have had any in the past: The statements made on this form are true and complete

1	Weight loss > 10lbs w/o diet		28	Breast lumps		55	Frequent diarrhea		82	Head injury	
2	Recent weight gain of > 10lbs		29	Breast surgery		56	Hepatitis or jaundice		83	Concussion	
3	Change in appetite		30	Frequent coughs		57	Hernia		84	Loss of consciousness	
4	Persistent fatigue		31	Bronchitis		58	Kidney infection		85	Memory loss	
5	Night sweats		32	Emphysema		59	Bladder infection		86	Sleep disturbance	
6	Skin rash		33	Asthma or wheezing		60	Kidney stones		87	Nervousness	
7	Glaucoma/cataracts		34	Pneumonia		61	Painful urination		88	Mental illness	
8	Wear glasses or contacts		35	Coughed up blood		62	Bloody urine		89	Fear of heights	
9	Blurred vision / double vision		36	High blood pressure		63	Urinating frequently night		90	Diabetes	
10	Eyes sensitive to light		37	Shortness of breath		64	Discharge from penis		91	Thyroid problems	
11	Sinus pain		38	Sleep on 2 more pillows		65	Arthritis		92	Goiter	
12	Ear surgery		39	Heart attack		66	Tendonitis/bursitis		93	Rheumatic fever	
13	Ear pain or discharge		40	Stroke		67	Swelling of joints		94	Polio	
14	Ear infection		41	Chest pain / angina		68	Fracture		95	Tuberculosis	
15	Frequent/ severe headache		42	Palpitation / heart flutter		69	Dislocation of joint		96	Venereal disease	
16	Dizziness		43	Heart murmur		70	Arm pain		97	Cancer	
17	Fainting		44	Calf pain		71	Arm/leg weakness		98	Multiple sclerosis	
18	Hearing aid		45	Ankle swelling		72	Weakness/tingling fingers		99	Carpal tunnel syndrome	
19	Change in hearing		46	Blood clots		73	Hand surgery		100	Silicosis	
20	Anorexia		47	Repeated infection		74	Knee injury/surgery		101	Asbestosis	
21	Bulimia		48	Frequent indigestion		75	Foot problems		102	Seizures/convulsions	
22	Recurrent mouth sores		49	Stomach pain		76	Muscle spasm			**For Women**	
23	Bleeding gums		50	Vomited blood		77	Back pain/injury		103	Problems with periods	
24	Difficulty swallowing		51	Change in bowl habits		78	Back surgery		104	Pregnancies #_____	
25	Persistent hoarseness		52	Bloody/black bowl		79	Tremors		105	Problems with pregnancy	
26	Neck injury		53	Frequent constipation		80	Anemia		106	Are you pregnant now	
27	Neck radiation		54	Hemorrhoids		81	Blood transfusion		107	Last menstrual period Date:	

_____ _____

Signature of patient **Date**

Please check if you have ever:

	Been, or now involved in litigation for personal injury		Been made ill by your work
	Been discharged from the military for health reasons		Received workers compensation
	Been rejected from the military for health reasons		Filed workers compensation claim
	Been refused employment for health reasons		Been refused life insurance
	Been forced to give up a job for health reasons		Collected pension for disability
	Moved from your home because of health risks		Worked with radioactive material

_____

_____

Patient Name:_____ DOB:_____

Communicable Disease History:

Please circle if you have ever had

Scarlet Fever	Yes	No
Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Hepatitis	Yes	No

Immunization Record:

Measles Vaccine _____ / _____ / _____

Rubella Vaccine _____ / _____ / _____

Hepatitis Vaccine _____ / _____ / _____

Flu Vaccine _____ / _____ / _____

Small Pox Vaccine _____ / _____ / _____

Tuberculin Test _____ / _____ / _____

Tetanus Toxoid _____ / _____ / _____

Section below to be completed by office:

Explanation of positive answers from page 2: _____

_____

_____

_____

_____

_____

_____

Signature of person reviewing form_____

TEST REPORTS

PPD #1: Date given: ___ / ___ / ___ Given by:	Left Forearm _____	Right Forearm _____
Results: Date of Read: ___ / ___ / ___ Read by:	Negative	Positive
PPD #2: Date Given ___ / ___ / ___ Given by:	Left Forearm _____	Right Forearm _____
Results: Date of Read: ___ / ___ / ___ Read by:	Negative	Positive
Positive reactor: Last Chest x-ray:	Yes	No
EKG: N/A	Negative	Positive
Rubella: Non Immune:_____ Date given: ___ / ___ / ___ Given by:	Right Deltoid	Left Deltoid
Measles: Date Given: ___ / ___ / ___	Right Deltoid	Left Deltoid
Color blindness test	Negative	Positive

Patient Name:_____ DOB:_____

Physical Examination:

(To be completed by Medical Provider)

Position:_____

Height:	Weight:	BP:	T:	P:	R:

Vision: Right eye: Left eye: Both eyes: Near Vision	Uncorrected 20 / ____ 20 / ____ 20 / 20	Corrected 20/ ____ 20 / ____ 20 /	Comments: Reads:_____ Corrected: Y N
	Normal	**Abnormal**	**Explanation**
Head: a. Eyes b. Ears			
Neck: a. Thyroid/ Lymphatics b. ROM c. Scar			
Lungs/Chest:			
Heart:			
Abdomen: a. Masses b. Hernias c. Scars			
Extremities: (Include ROM for knees) a. Reflexes / Strength b. Range of Motion			
Back: a. Movement/ROM b. Posture c. Scars			

Medical Provider Signature: _____ Date: _____

Patient Name:_____ DOB:_____

Are there any muscular skeletal problems that would affect the individual's physical capability to do any job?

Circle: Yes No Explain:_____

_____

_____

Work Limitations for current position: Explain: _____

_____

_____

Any additional comments: _____

_____

_____

Is this person medically qualified for this job placement: Circle Yes No Explain: _____

_____

_____

_____ _____

Signature of Medical Provider **Date:**

Patient Name:_____ **DOB:**_____