



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (First) (Middle) (Last)

Employer: \_\_\_\_\_ Job: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**PHYSICAL EXAMINATION**

SEX <input type="checkbox"/> Female <input type="checkbox"/> Male		HEIGHT	WEIGHT  LBS	PULSE	BLOOD PRESSURE
Urinalysis:	Albumin	Sugar	Specific Gravity	Other	

Right-Handed  Left-Handed

General Appearance	Normal	Abnormal	Comments																									
<b>Visual Acuity:</b> <table border="1"> <tr> <td></td> <td>Uncorrected</td> <td>Corrected</td> <td>Uncorrected</td> <td>Corrected</td> </tr> <tr> <td></td> <td>Far</td> <td>Far</td> <td>Near</td> <td>Near</td> </tr> <tr> <td>Both</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> </tr> <tr> <td>Left</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> </tr> <tr> <td>Right</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> <td>20/___</td> </tr> </table>					Uncorrected	Corrected	Uncorrected	Corrected		Far	Far	Near	Near	Both	20/___	20/___	20/___	20/___	Left	20/___	20/___	20/___	20/___	Right	20/___	20/___	20/___	20/___
	Uncorrected	Corrected	Uncorrected	Corrected																								
	Far	Far	Near	Near																								
Both	20/___	20/___	20/___	20/___																								
Left	20/___	20/___	20/___	20/___																								
Right	20/___	20/___	20/___	20/___																								
Peripheral vision: Degrees Left: Right:																												
Color Vision: (Ishihara) /10																												
Eyes																												
Hearing																												
Throat																												
Thyroid																												
Neck																												
Lungs																												
Heart																												
Abdomen																												
Hernia																												
Back																												
Upper Extremities																												
Tinel's, Phalen's Signs																												
Lower Extremities																												
Neurological Status																												
Emotional Status																												

Medical Conditions: \_\_\_\_\_

Examiner Signature: \_\_\_\_\_ Date: \_\_\_\_\_



This examination is for the purpose of assisting the employment department in placing you in a job safe to yourself and others according to your physical ability. A physical impairment does not necessarily disqualify you. Your cooperation in answering the following questions is requested. Do you now or have you ever had: (check the appropriate box for each item. If yes, please explain.)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Symptom	Yes	No	Explanation
Heart disorder			
Lung disorder			
Asthma or shortness of breath			
Migraine headaches			
Allergy problems			
Stomach or intestinal trouble			
Liver or gall bladder trouble			
Yellow skin or eyes or yellow jaundice			
Hernia or rupture			
Kidney trouble			
Sugar or protein in urine			
Poor eyesight-wear glasses			
Ear trouble or loss of hearing			
Convulsions or epilepsy			
Loss of part (arm, finger, leg, foot, etc.)			
Deformity			
Back injury or previous myelogram			
Rash due to chemicals (oils, plastics, etc.)			
An operation or surgery or advised to have an operation			
Illness or injury from chemical exposures			
Rejection or discharge from military service for physical reasons to be a patient in the hospital			
Illness or injury due to work			
Allergies to medications			
Smoke cigarettes			Packs per day:
Arthritis (joint pain)			
Tendonitis			
Current medication			

Signature \_\_\_\_\_

Date: \_\_\_\_\_