Physical Exam Form (non-D.O.T.)

Occupational Health

Full Name:____

Occupational History

Please list dates, employer and occupations you have worked in last five years. Please print.

Dates		Company	Occupation
From	To		

Check if you have worked in the following occupations:

☐ Asbestos ☐ Foundry ☐ Grinding ☐ "Sand Blasting" ☐ Silica ☐ Spray/Brush Painting

☐ Plating ☐ Glass Mfg. ☐ Mining (kind):_______________________ ☐ Stone Cutting

Check if you have ever been exposed to any of the following (whether at home, work, or in any setting):

☐ Substances which caused you breathing difficulties
☐ Substances which irritated your skin or eyes
☐ Sprays/powders for insects or plants
☐ Prolonged loud noises
☐ Dusty conditions, such as sandblasting, binding or drilling of rock, coal, silica, or asbestos products

Have you ever had an adverse (bad) reaction to:

☐ High environmental temperatures ☐ Low environmental temperatures ☐ Scents (perfumes, chemicals, etc.) ☐ High altitudes or heights

Please answer all of the following questions by checking "yes" or "no."

1. Have you ever had back pain which caused you to remain in bed or miss work? ☐ Yes ☐ No

   If yes, for how long?_______________How often?_______________

2. Have you ever seen a medical practitioner of any kind for a back problem? ☐ Yes ☐ No

   If yes, when? ___________By whom?_______________

3. Have you ever been hospitalized for a back problem? ☐ Yes ☐ No

   If yes, what facility?_______________________
   When?_____________ Surgery?_______________

4. Have you had X-rays or other studies of your back? ☐ Yes ☐ No

   If yes, what facility?_______________________
   Mylogram?_______CT Scan?___________Abnormal?___________

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Patient Label

5. Have you ever had a bad back? ☐ Yes ☐ No
   If yes, describe?________________________________
6. Have you ever injured your back in an automobile accident? ☐ Yes ☐ No
   If yes, the type of injury?________________________________
   Treated by whom?________________________________
7. Have you ever been denied employment because of a back problem or abnormal X-ray or other test? ☐ Yes ☐ No
8. Do you have back pain now? ☐ Yes ☐ No
9. Have you had back pain recently? ☐ Yes ☐ No
10. Have you ever seen a chiropractor? ☐ Yes ☐ No
    If yes, how often?________________Who?________________
11. Do you currently lift weights? ☐ Yes ☐ No
12. Have you ever seen a medical practitioner of any kind for carpal tunnel syndrome and/or tendonitis? ☐ Yes ☐ No
    If yes, when?________________By whom?________________
13. Within the last 5 years please mark ( ) if you have experienced any of the following:
    ☐ Numbness/tingling in the hand and fingers ☐ Swelling of the thumb, wrist or fingers
    ☐ Pain in the thumb, wrist or fingers ☐ Decreased ability to grasp objects between fingers and thumb
    ☐ Wake up in the night with tingling or numbness in hand or fingers
    ☐ Decreased sensation to hot and cold in the hand and fingers
14. Have you lost any work in the last 5 years because of an arm or hand injury? ☐ Yes ☐ No
    If yes, how many days?__How many times?________Last Visit:____________

Medical Profile

Check any of the following conditions that apply or have ever applied to you:

15. ☐ Alcoholism
16. ☐ Drug Abuse
17. ☐ Asthma
18. ☐ Allergies
19. ☐ Hay Fever
20. ☐ Shortness of Breath
21. ☐ Coughing/Frequent Colds
22. ☐ Coughing Blood
23. ☐ Nose or Sinus Trouble
24. ☐ Pneumonia or Pleurisy
25. ☐ Tuberculosis/ LungTrouble
26. ☐ Hearing Difficulties
27. ☐ Bowel Habit Change
28. ☐ Liver Disease or Jaundice
29. ☐ Stomach Trouble, Nausea, Vomiting
30. ☐ Ulcers
31. ☐ Vomiting Blood
32. ☐ Hemorrhoids or Rectal Trouble
33. ☐ Back or Spinal Injury
34. ☐ Back Trouble or Sore Back
35. ☐ Dislocated Vertebra
36. ☐ Neck Strain or Stiffness
37. ☐ Broken Bones or Bone Disease
38. ☐ Elbow Injury or Trouble
39. ☐ Foot Trouble, Deformed Foot
40. ☐ Joint Problems
41. ☐ Knee Injury
42. ☐ Rheumatism or Arthritis
43. ☐ Shoulder, Arm, or Hand Pain
44. ☐ Trick or Locked Knee
45. ☐ Diabetes
46. ☐ Gall Bladder Trouble
47. ☐ Thyroid Trouble
48. ☐ Gout
49. ☐ Heart Trouble – Pain/Attack
50. ☐ Chest Pain
51. ☐ High Blood Pressure
52. ☐ Swelling of Ankles or Feet
53. ☐ Varicose Veins
54. ☐ Polio or Meningitis
55. ☐ Stroke
56. ☐ Epilepsy
57. ☐ Headache/Migraine, Frequent/Severe
58. ☐ Head Injury – Any Type
59. ☐ Fainting Spells or Dizziness
60. ☐ Nervous Trouble or Breakdown
61. ☐ Numbness/Weakness/Tiredness
62. ☐ Anemia or other Blood Diseases
63. ☐ Cancer, Cyst, Growth or Tumor
64. ☐ Boils or Skin Disease
65. ☐ Rash or Hives
66. ☐ Hernia

Please list all over the counter and prescription medications you are currently taking:________________________________

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Please answer each of the following:

67. Have you had or have now, illnesses or injuries other than those listed above? ☐ Yes ☐ No
68. Have you ever seen an orthopedist? ☐ Yes ☐ No
69. Have you ever had, or been advised, to have surgery? ☐ Yes ☐ No
70. Have you any physical complaint, impairment or disability at present? ☐ Yes ☐ No
71. Are you taking any medicines, supplements, or drugs now? ☐ Yes ☐ No
72. Are you under the care of a doctor, healer, or other practitioner at the present time? ☐ Yes ☐ No
73. Is there any reasons you would be UNWILLING or UNABLE to wear required safety protection such as safety shoes, hard hat, safety glasses, ear plugs, ear muffs, gloves and other required safety gear? ☐ Yes ☐ No
74. Were you medically discharged from the military? ☐ Yes ☐ No
75. Do you have a service connected disability? ☐ Yes ☐ No
76. Do you have any form of permanent disability as a result of an on the job injury? ☐ Yes ☐ No
77. Have you ever had a work related injury or illness? ☐ Yes ☐ No
78. In the past five years, how many weeks have you lost from work related injury? ☐ Yes ☐ No
79. When was your last tetanus shot?____________________

List all significant medical problems and hospitalizations, including operations or injuries such as any injury to muscles, joints, ligaments, back or neck in any work, sports, motor vehicle accident or other incident. List the most recent, first.

Date	Medical Problems/Operations/Injuries	Causing Problem Now?	
		Yes	No

I understand that this physical examination is being done to help my employer place me in a position for which I am medically qualified and that this examination is not intended to replace my routine, annual physical examination with my primary care doctor. I hereby certify that, to the best of my knowledge, the foregoing answers are complete and correct.

Signature of Worker:____ Date:____________________

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