Company:_____

Job Title: _____

Date: _____

Exam: RN PA MD Other

MEDWORK
Initial Occupational History & Physical Examination

Name	Date of Birth	Age	Sex	Social Security #
Address	Telephone #	Personal Physician		
City, State, Zip	Notify in Case of Emergency		Telephone #	

Personal History - Answer YES or NO to any past or present problems for all of the following conditions:

CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. DIABETES or ELEVATED BLOOD SUGAR			29. LIVER or GALLBLADDER PROBLEMS		
2. LOW BLOOD SUGAR			30. ULCERS or GASTRITIS		
3. GOITER or THYROID DISORDER			31. COLITIS or OTHER BOWEL DISORDERS		
4. SEIZURES, EPILEPSY			32. DIGESTIVE PROBLEMS		
5. FAINTING, DIZZINESS, LOSS OF or ALTERED CONSCIOUSNESS			33. KIDNEY DISEASE or STONES		
6. HEAD/BRAIN INJURIES-PROBLEM CONCENTRATING			34. ARTHRITIS, GOUT, RHEUMATISM		
7. HEADACHES-FREQUENT or SEVERE			35. MUSCULAR DYSTROPHY		
8. STROKE or TIAS (MINI STROKE)			36. AMPUTATED/IMPAIRED HAND,ARM, FOOT, LEG, FINGER, TOE		
9. SLEEP DISORDERS			37. MUSCLE, BONE or JOINT PAIN, DISCOMFORT or SWELLING		
10. CANCER or TUMORS			38. SHOULDER, ARM, WRIST, HAND PAIN DISORDER		
11. BLOOD DISEASE (INCLUDING ANEMIA)			39. NECK or BACK PROBLEMS		
12. EYE DISORDERS or IMPAIRED VISION (EXCEPT CORRECTIVE LENSES)			40. CHRONIC BACK or NECK PAIN		
			41. KNEE INJURY or PROBLEMS		
13. EAR DISORDERS, LOSS OF HEARING, or BALANCE			42. SKIN PROBLEMS or DERMATITIS		
14. HIGH BLOOD PRESSURE			43. HERNIA		
15. CARDIAC DISEASE-HEART ATTACK; OTHER CARDIOVASCULAR CONDITION			44. MEN - PROSTATE PROBLEMS		
			45. FEMALE - CURRENTLY PREGNANT		
16. HEART SURGERY or OTHER HEART DISEASE			46. FEMALE - ANY FEMALE or GYNECOLOGIC DISORDERS		
17. CHEST PAIN			47. SIGNIFICANT INFECTIOUS DISEASE - HEPATITIS, HIV, or AIDS		
18. THROMBOPHLEBITIS (BLOOD CLOTS)			48. FEAR OF HEIGHTS or TIGHT PLACES		
19. ANY LUNG or RESPIRATORY PROBLEMS			49. CURRENT or PREVIOUS DEPENDENCE ON MEDICATION or DRUGS		
20. EMPHYSEMA or BRONCHITIS					
21. ASTHMA or DIFFICULT BREATHING			50. EVER BEEN REFUSED or CHANGED EMPLOYMENT DUE TO YOUR HEALTH		
22. TUBERCULOSIS or POSITIVE TB TEST					
23. NERVOUS or PSYCHIATRIC DISORDER			51. ANY PERMANENT or PARTIAL ACTIVITY RESTRICTIONS		
24. ANXIETY or DEPRESSION			52. EVER BEEN DETERMINED TO BE DISABLED		
25. NERVE or NEUROLOGIC DISORDER			53. ANY ILLNESS or INJURY or SURGERY NOT PREVIOUSLY MENTIONED		
26. CEREBRAL PALSY					
27. MULTIPLE SCLEROSIS			54. RECEIVED MEDICAL or PSYCHOLOGICAL TREATMENT IN THE LAST 5 YEARS (NOT PREVIOUSLY LISTED)		
28. ALZHEIMER'S or PARKINSON'S DISEASE					

Please Describe all "Yes" Answers (Identify by Number): _____

_____

_____

_____

List all Allergies: _____

List all Medications & Drugs Used in the Past Six Months: _____

_____

Do you Use Alcohol ____ If "Yes" How Much Daily _____ How Much Weekly _____Do you Use Tobacco____ If "Yes" How Much Daily _____ How Much Weekly _____

Staff Comments: _____

_____

_____

I declare each of my answers to be full, complete and true to the best of my knowledge. I understand that any false statement or misrepresentation in answering the above could cause my immediate discharge regardless of when such fact may be discovered. I hereby authorize the above named company or its authorized agent to perform or have performed on my person a physical examination according to requirements established by the above named company, and any applicable government agency, including, but not limited to, X-rays and laboratory tests. I hereby authorize MedWork and the medical laboratory, or any other facility participating in this examination to disclose to the above named company information regarding conditions for which I was or am now under their observation or treatment, or of which they have knowledge, to disclose such information including, history, findings, or diagnoses to MedWork or to the above company.

Patient Signature _____ **Date** _____