

Date:
Pre-placement:
Periodic:
Other:

# Occupational/Medical Health Examination

Name:

S.S.#

Personal Physician:

Date of Birth:

Sex:

**Job History** Past:

Current:

Hiring Employer:

Position Hired for:

Have you ever had or do you now have:	Yes	No	Give details of all "Yes" answers
1. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	
2. Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	
3. Unconsciousness for any reason	<input type="checkbox"/>	<input type="checkbox"/>	
4. Numbness or tingling sensation (specify)	<input type="checkbox"/>	<input type="checkbox"/>	
5. Moderate to severe pain	<input type="checkbox"/>	<input type="checkbox"/>	
6. Lost time from work-related illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	
7. Eye trouble other than need for glasses	<input type="checkbox"/>	<input type="checkbox"/>	
7a. Do you wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last eye exam			
8. Lung trouble (other than colds)	<input type="checkbox"/>	<input type="checkbox"/>	
9. Breathing difficulty, asthma, wheezing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
10. Known exposure to Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
11. High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
12. Heart trouble (angina or palpitation)	<input type="checkbox"/>	<input type="checkbox"/>	
13. Indigestion or other stomach trouble	<input type="checkbox"/>	<input type="checkbox"/>	
14. Kidney or bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	
15. Hernia-specify	<input type="checkbox"/>	<input type="checkbox"/>	
16. Liver trouble-hepatitis or jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
17. Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	
18. Nervous trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	
19. Unintentional weight changes	<input type="checkbox"/>	<input type="checkbox"/>	
20. Use of narcotics or street drugs	<input type="checkbox"/>	<input type="checkbox"/>	
21. Regular alcohol use-specify amount	<input type="checkbox"/>	<input type="checkbox"/>	
22. Smoking habit-packs per day and # years	<input type="checkbox"/>	<input type="checkbox"/>	
23. Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	
24. Any bone or joint pain or limitations	<input type="checkbox"/>	<input type="checkbox"/>	
25. Any hand or wrist pain, numbness, tingling or carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
26. Exposure to radiation, x-rays, scans	<input type="checkbox"/>	<input type="checkbox"/>	
27. Rejected for life insurance	<input type="checkbox"/>	<input type="checkbox"/>	
28. Military medical discharge or rejection	<input type="checkbox"/>	<input type="checkbox"/>	
29. Surgery-specify	<input type="checkbox"/>	<input type="checkbox"/>	
30. Admission to hospital or treatment	<input type="checkbox"/>	<input type="checkbox"/>	
31. Other	<input type="checkbox"/>	<input type="checkbox"/>	
32. <b>Women Only:</b> Date of last Pap Smear			
33. <b>Men Only:</b> Date of last Prostate Check			

Work Related Exposures:

Medications:(regular or prescribed)

Allergies:

Medical Treatment since last report:

I certify that my answers to the foregoing questions are true and complete, to the best of my knowledge. I understand and agree that my answers and physical examination findings may be used to aid in my placement in a job which is compatible with my health status. I also agree to submit blood, urine and breath samples required for the Company's health and safety programs, including but not limited to toxic substances, controlled substances (drugs) & intoxicants, when requested to do so by the Company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*For Office Use Only*

**Assessment/Recommendations**