# Employee Health Medical Record

| Name: | | Date: |
|---|---|---|
| Address: | City: | State, Zip: |
| Phone (Home/Cell): | (work): | Sex: F M |
| Email Address: | | DOB: |
| Primary Care Provider: | Town of Primary Care Provider: | |
| Date of Last Physical with your Primary Care Provider: | | |
| 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 including prescriptions, vitamins, and supplements? **Yes** **No**
If yes, what are they:__________________________________________________

Do you smoke tobacco? **Yes** **No** If yes, # of packs per day_________ / Years________

If you smoked in the past, when did you quit? __________

Do you use any addictive substances? **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 health issues you have: ☐NONE |
|---|
| Do you have any allergies to medication, food or chemical? If so, please describe reaction: ☐NONE |

| Job Applied for: |
|---|
| Current job: |

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

| # | Condition | | # | Condition | | # | Condition | | # | Condition | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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: | |

**Please circle if you have ever had the following:**

| | | | | | |
|---|---|---|---|---|---|
| Been, or now involved in litigation for personal injury | Yes | No | Been made ill by your work | Yes | No |
| Been discharged from the military for health reasons | Yes | No | Received workers compensation | Yes | No |
| Been rejected from the military for health reasons | Yes | No | Filed workers compensation claim | Yes | No |
| Been refused employment for health reasons | Yes | No | Been refused life insurance | Yes | No |
| Been forced to give up a job for health reasons | Yes | No | Collected pension for disability | Yes | No |
| Moved from your home because of health risks | Yes | No | Worked with radioactive material | Yes | No |

**Please circle if you have or have had in the past:**

| | | |
|---|---|---|
| Back or Neck Injury or Pain? | Yes | No |
| Joint or Muscle Injury or Pain? | Yes | No |
| Do you have any Hernias? | Yes | No |
| History of Motor Vehicle Accidents? | Yes | No |
| History of any Sport Injuries? | Yes | No |

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 |
| Covid-19 | Yes | No |

**Immunization Record:**

☐ Vaccinated as a child in the USA

MMR Vaccine _____ / _____ / _____

Hepatitis B Vaccine _____ / _____ / _____

Flu Vaccine _____ / _____ / _____

Varicella Vaccine _____ / _____ / _____

Tetanus Toxoid _____ / _____ / _____

COVID-19 Vaccine ______ / _____ / _____

The statements made on this form are true and complete.

_______________________________________ ____________________

**Signature of patient** **Date**

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**Section below to be completed by office:**

**Explanation of positive answers from page 2 & 3:** ____________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

**Signature of person reviewing form:** ______________________________ **Date:** ____________

**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 |

Patient Name:____________________________________ DOB:________________

# Physical Examination:

(To be completed by Medical Provider)

Position:______________________________________________________________

| Height: ft in | Weight: lbs | BP: | Temp: ºF | HR: |
|---|---|---|---|---|
| BMI: | | Repeat BP: | RR: | Pulse Ox: % |

| Vision:<br>Right Eye:<br>Left Eye:<br>Both Eyes:<br>Near Vision | Uncorrected<br>20 / ____<br>20 / ____<br>20 / ____<br>20 / ____ | Corrected<br>20/ ____<br>20 / ____<br>20 / ____<br>20 / ____ | Comments: |
|---|---|---|---|
| Color Blindness Test | Negative | Positive | |
| | **Normal** | **Abnormal** | **Explanation** |
| Head:<br>a. Eyes<br>b. Ears | | | |
| Neck:<br>a. Thyroid/ Lymphatics<br>b. ROM<br>c. Scar | | | |
| Lungs/Chest: | | | |
| Heart: | | | |
| Abdomen:<br>a. Masses<br>b. Hernias<br>c. Scars | | | |
| Extremities: (Include ROM for knees)<br>a. Reflexes / Strength<br>b. Range of Motion | | | |
| Back:<br>a. Movement/ROM<br>b. Posture<br>c. Scars | | | |

Patient Name:_______________________________________ DOB:________________

**Are there any musculoskeletal problems that would affect the individual's physical capability to do THIS 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 Pending Explain:** __________

______________________________________________________

______________________________________________________

________________________________ ____________________

**Signature of Medical Provider** **Date:**

**Patient Name:**______________________________ **DOB:**________________