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<tbody>
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<td>DRUG ALLERGIES:</td>
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<td>VISION:</td>
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<td>Corrected?</td>
<td>Yes</td>
<td>No</td>
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3. NECK / HEAD
4. E.E.N.T.
5. HEART
6. LUNGS
7. BREASTS
8. ABDOMEN
9. RECTAL
10. GENITALIA
11. MUSCULOSKELETAL
12. EXTREMITIES
13. VASCULAR-PULSES
14. NEUROLOGICAL
15. SKIN
16. LYMPHATICS

NEG POS (Explain positive findings.)

ASSESSMENT / DIAGNOSIS:

PLAN:

CLINICIAN SIGNATURE / TITLE: | DATE: | PHYSICIAN SIGNATURE: | M.D. | DATE: |
**MEDICAL HISTORY FORM**

Pre-Employment: ____________
Annual: ____________
Men / Women's Assessment: ____________
Injury: ____________

**NAME:**

**ADDRESS:**

**SOCIAL SECURITY #:**

**DATE OF BIRTH:**

**PLACE OF BIRTH:**

**TEL # (HOME):**

**TEL # (WORK):**

**EMPLOYER:**

**OCCUPATION:**

**PHYSICIAN:**

**PHYSICIAN TEL #:**

**DATE OF LAST DOCTOR'S OFFICE VISIT:**

**REASON:**

**CURRENT MEDICAL PROBLEMS:**

**CURRENT MEDICATIONS:**

**MEDICATION ALLERGIES:**

**ENVIRONMENTAL ALLERGIES:**

**SEASONAL ALLERGIES:**

**OTHER ALLERGIES:**

**HEART TROUBLE**

**TUBERCULOSIS**

**STOMACH / ULCER**

**PSYCHIATRIC TREATMENT**

**SURGERY**

**AUTO ACCIDENT**

**BACK INJURY**

**FREQUENT HEADACHES**

**HOSPITALIZATION**

**NEEDLESTICK INJURY**

**ORTHOPEDIC PROBLEM**

**ASTHMA**

**HIGH BLOOD PRESSURE**

**DIABETES**

**DERMATITIS / SKIN TROUBLE**

**WORK RELATED INJURY** (If checked, did you receive WORKER'S COMPENSATION? ___ YES ___ NO)

**HAVE YOU TRAVELED OUTSIDE THE USA IN THE PAST (1) YEAR?**

**DO YOU SMOKE CIGARETTES?**

**DO YOU DRINK ALCOHOL?**

**DO YOU USE OTHER RECREATIONAL DRUGS?**

**DO YOU REGULARLY EXERCISE?**

**TYPE OF EXERCISE:**

**IMMUNIZATIONS**

**DATE**

**DATE OF LAST**

**BCG VACCINE**

**DENTAL EXAM**

**TD VACCINE**

**EYE EXAM**

**MMR VACCINE**

**PPD TEST**

**HEPATITIS B**

**EVER TREATED FOR TB?**

**POSITIVE**

**NEGATIVE**

**YES**

**NO**

**WOMEN ONLY**

**LAST MENSTRUAL PERIOD:**

**LAST PAP SMEAR:**

**RESULTS:**

**MEN ONLY**

**LAST RECTAL / PROSTATE EXAM:**

**LAST PSA:**

**RESULTS:**

---

**I GIVE MY CONSENT FOR A PHYSICAL EXAMINATION THAT MAY INCLUDE SUCH TESTS / PROCEDURES AS DEEMED NECESSARY.**

**NAME (Printed):**

**SIGNATURE:**

**DATE:**

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

**NAME:**

**DAYTIME TEL #:**

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8850388 Rev. 05/05

Physical Examination_WELLNESS

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