OCCUPATIONAL HEALTH PHYSICAL EXAM

Exam Date:	**Name:**		
Date of Birth:	**Age:**	**Sex:** Male: ☐ Female: ☐	**Phone:** / **Cell/Pager:**
Address:			

HAVE YOU EVER HAD ANY OF THE FOLLOWING HISTORY, ILLNESSES OR COMPLAINTS?

Check each item and give date if "yes"	NO	YES	Date	Check each Item and give date if "yes"	NO	YES	Date
Abdominal Complaints				Frequent Sore Throat or Cold			
Arthritis/Tendonitis				Gallstones			
Asthma				Goiter			
Back Injury/Pain				Headaches, severe or frequent			
Blood or Pus in Urine				Heart Disease			
Broken Bones				Hepatitis A B C (Circle One)			
Bronchitis				High Blood Pressure			
Burning on Urination				HIV			
Cancer or Tumor				Kidney Disease			
Carpal Tunnel/Hand Tingling				Liver Disease/Jaundice			
Crohn's Disease				Loss of Appetite			
Diabetes				Nervousness			
Dizziness				Pneumonia			
Drug and/or Alcohol Abuse				Rheumatic Fever			
Dysentery/Diarrhea				Sensitivity to Latex?			
Ear Troubles/Hearing Difficulty				Sinus Troubles			
Eczema/Rash				Sleep Disorders/Sleep Apnea			
Epilepsy/Seizures				Smoking or tobacco use			
Eye Disease				Stroke			
Frequency of Urination				Tuberculosis			
Have you ever had Injuries Away From Work?				Have you ever had Injuries or Illnesses Due to Work?			

Explain any "yes" answers:

Other Illnesses or Pertinent History?

Do You Have Any Allergies?

Date/s of Surgery (List Previous Surgeries (Specify Right/Left))

Have You Ever Had A Physician recommend surgery and NOT had surgery? ☐ No ☐ Yes If Yes, Explain.

Have You Ever Been Hospitalized?: ☐ No ☐ Yes **List Reasons for Admission and Dates:**

Medications or Herbals Taken?:

Have You Ever Had A Physician recommend permanent restrictions? ☐ No ☐ Yes **If Yes**, List Restrictions:

I acknowledge that all of the above information is, to the best of my knowledge, true and complete.

Patient Signature _____ **Date** _____