

# PHYSICAL EVALUATION

Name: \_\_\_\_\_ SS# \_\_\_\_\_ Pre-Employment \_\_\_\_\_ Annual \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

## HEALTH HISTORY

Yes	No	Any illness or injury in last 5 years?	Yes	No	Lung disease, emphysema asthma, chronic bronchitis	Yes	No	Fainting, dizziness
Yes	No	Head/Brain injuries, disorders or illness	Yes	No	Kidney disease, dialysis	Yes	No	Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
Yes	No	Seizures, epilepsy Meds:	Yes	No	Liver disease	Yes	No	Stroke or paralysis
Yes	No	Eye disorders or impaired vision (except correction)	Yes	No	Digestive problems	Yes	No	Missing or impaired hand, arm, foot, leg, finger, toe
Yes	No	Ear disorders, loss of hearing or balance	Yes	No	Diabetes or elevated Blood sugar controlled by: Diet / Pills / Insulin	Yes	No	Spinal injury or disease
Yes	No	Heart disease or heart attack; other cardiovascular condition: Meds:	Yes	No	Nervous or psychiatric disorders, e.g. severe depression Meds:	Yes	No	Chronic low back pain
Yes	No	Heart surgery (valve replacement/ bypass, angioplasty, pacemaker)	Yes	No	Loss of or altered consciousness	Yes	No	Regular, frequent alcohol use
Yes	No	High blood pressure Meds:	Yes	No	Muscular disease	Yes	No	Narcotic or habit forming drug use
Yes	No	Shortness of breath						

For any YES answer, Explain:

I am free from any communicable disease, in the communicable state.  Yes  No

I CERTIFY THAT THIS INFORMATION IS TRUE, AND I CONSENT TO A PHYSICAL EXAM:

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

### PHYSICAL EXAM

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Appearance:  Good  Fair  Poor Build:  Slender  Medium  Obese

Vision: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Both 20/ \_\_\_\_\_  with corrective lenses  without corrective lenses

### PHYSICAL EXAM

Check if normal		Note details ..... please use separate sheet if more space is needed
Skin scars	<input checked="" type="checkbox"/>	
Head/neck		
Eyes/ears		
Mouth/throat		
Thyroid		
Heart/vessels		
Chest/lungs		
Abdomen/viscera		
Absence of hernia		
Genito-urinary		
Extremities		
Reflexes		
Spine/musculoskeletal		
Joints		
Neurological		

Psychological status: \_\_\_\_\_

Note any limitations: \_\_\_\_\_

The applicant has been advised of findings:  Yes  No

The applicant has been referred to his personal physician:  Yes  No

Applicant free of communicable diseases per interview:  Yes  No

Date: \_\_\_\_\_ Signature of Examining Physician: \_\_\_\_\_

**Return to:** Wellness \_\_\_\_\_, ER \_\_\_\_\_

Date: \_\_\_\_\_ After (Time) \_\_\_\_\_

OR

Date: \_\_\_\_\_ Before (Time) \_\_\_\_\_

If your PPD is not read in this time frame,  
you will be expected to get another.

Memorial Hospital, Inc.  
Towanda, PA 18848  
Employee Health Program

## MANTOUX (PPD) TEST

Employee Name: \_\_\_\_\_

Department: \_\_\_\_\_

### History:

Have you ever had a positive reaction to previous PPD? \_\_\_\_\_ Yes \_\_\_\_\_ No

If **Yes** date of last Chest X-Ray: \_\_\_\_\_

**If test is not to be completed for reasons other than “positive reaction”**

**Explain why:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Test Given:

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Location:**     Right             Left Foreman

Serum Lot Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Test Performed By: \_\_\_\_\_

Nurse's Signature

### Test Results: (Must be read in 48 to 72 hours)

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Test Read By: \_\_\_\_\_

Nurse's Signature

Results: \_\_\_\_\_ mm

### Follow-up: If Positive Action Taken:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Remarks:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_