OCCUPATIONAL HEALTH HISTORY/ EXAM

Prior to your exam please complete the next three pages. Sign your name at the bottom of the third page. The health care provider will review the information and complete the fourth page.

THIS EXAMINATION IS TO DETERMINE WORK CAPABILITIES ONLY.

IT IS NOT INTENDED TO TAKE THE PLACE OF A REGULAR

EXAMINATION BY YOUR PRIVATE HEALTH CARE PROVIDER.

Full Name: _____ Date of Birth: _____

Phone: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Company: _____ Position Applied For: _____

Please check list below and complete:

HAVE YOU EVER HAD:	Yes	No	Year		Yes	No	Year
Head injury, skull fracture, whiplash				Gallstones			
Headaches, dizzy or fainting spells				Kidney problems, frequent urination			
Mental, nervous, brain problems				Hepatitis or jaundice			
Convulsions, epilepsy or black-outs				Liver problems			
Asthma or allergy *(to food chemicals, medications)*				Hernia or rupture			
Vision loss, blindness, color blindness				Foot or ankle problems			
Ear trouble, decreased hearing				Varicose veins, leg ulcers			
Diabetes				Hand, wrist or elbow problems			
Frequent nosebleeds				Stiff joints: trick shoulders or knees			
Frequent trouble swallowing				Shoulder problems *(rotator cuff etc.)*			
Hoarseness				Back problems *(injury, strain, herniated disc)*			
Rheumatic fever				Bursitis, tendonitis			
Chronic bronchitis, cough or pneumonia				Rheumatism, arthritis, gout			
Tuberculosis or spitting blood				Hospitalizations for illness or injury			
Chest pain or shortness of breath				Anemia or bleeding problems			
Swelling of legs or ankles				Rash from contact or allergy			
High blood pressure or stroke				Fractures of any degree			
Stomach trouble, ulcers				Scars or identifying marks			
Tumor or Cancer				Do you wear contact lenses			
Heart trouble				Muscle disorder			

Comments: _____

Please check one ✓

Have you ever worked at or in any of the following occupations?	Yes	No		Yes	No
Mining			Asbestos		
Pottery			Quarrying and Stone Cutting		
Sand Blasting			Welding		
Foundry			Car Body Repair and Lead Grinding		
Glass Manufacturing			Radiation Materials Exposure		
Brick Manufacturing			Wood Working		

List other past positions _____

_____

Please check one ✓

Have you ever had difficulty with these types of physical demands?	Yes	No		Yes	No
Standing 7-8 hours/day			Frequent lifting greater than 50 pounds		
Twisting/bending of wrists *(constant or periodic/ heavy or light/*			Fine hand movements *(repetitive/changes)*		
Driving Vehicle			Operating machinery		
Close eye work			Other		
Kneeling			Exposure to hazardous materials (i.e., chemicals, excessive heat or radiation)		
Bending or twisting					

PERSONAL HISTORY

When was your last physical, EKG, exam and or x-rays taken? _____

Where: _____

Was there a reason for this or was it routine? please explain. _____

_____

List all medications you are currently taking. _____

_____

	Yes	No
Do you smoke cigarettes? _____		
If yes, how many per day? _____		
For how many years? _____		
Do you drink alcohol? _____		
If yes, drinks per week? _____		
Have you had injuries or illnesses in the past that happened at work? _____		
If yes, please explain _____		
Do you or have you ever had numbness or tingling in the hand or been awakened at night because of pain in your hand? _____		
If yes, please explain _____		

Please check one ✓	Yes	No
Have you ever had numbness or electrically sharp pain traveling into your fingers/hands at any time? If yes, please explain _____		
Have you ever had any arm, leg, hand or foot problems (i.e., sprains, injury, fracture, dislocation, tendonitis)? If yes, please explain		
Do you or have you ever worn a supportive brace for your wrist, back or knee? If yes, please explain _____		
Have you ever had any back trouble or back injuries? If yes, please explain _____		
Do you have any condition that may require a special work assignment, restrictions or accommodation if you are hired? (i.e., walking, bending, lifting, standing, grasping, repetitive activity/exercise?) If yes, please explain _____		
Do you have any presence of swelling in your arms or legs? If yes, please explain _____		
Have you developed hearing loss from noise exposure? If yes, please explain _____		
Have you ever developed a health problem from using a vibrating tool? If yes, please explain _____		
Have you ever developed a health problem from exposure to chemicals, dusts, or fumes? If yes, please explain _____		
Do you have any physical defects or partial disability? If yes, please explain _____		
Have you ever received a pension, insurance payment or compensation for any work related injury? If yes, please explain _____		
Have you ever received a Veteran Benefit due to injury? If yes, please explain _____		
Have you ever been injured in a car accident: If yes, please explain _____		
Have you ever been evaluated or treated for chemical dependency? If yes, please explain _____		
Have you been advised to have a surgical operation or medical treatment that has not been done? If yes, please explain _____		
Are you presently under the care of a physician or chiropractor? If yes, please explain _____		
Do you have any other concerns not mentioned above? If yes, please explain _____		

I hereby certify that I have answered the questions above to the best of my knowledge and that the answers are true and complete.

I give permission for the examining physician to release any information from this history and from the physical examination, lab, x-rays to the company that requested this examination. This also includes information from my past history if it impacts on my ability to perform the job.

Signature_____ **Date**_____

VIBRANT HEALTH FAMILY CLINICS
PHYSICAL EXAMINATION RECORD

Full Name: _____ Date of Exam:_____

Allergies: _____ Medication:_____

Family History: Explain any significant familial diseases such as Hypertension, Heart Disease, Diabetes, Cancer etc.

_____

_____

_____

General Appearance: Good _____ Fair _____ Poor _____ HT _____ WT _____ BP _____ P _____

Vision: R 20/_____ L 20/_____ Both 20/_____ _____ With_____ Without corrective lenses

Color Vision: Normal _____ Abnormal _____ Depth: Normal _____ Abnormal _____

Audiogram: _____ Not requested _____ Completed

Pulmonary Screen: _____ Not requested _____ Completed

Physical Exam	Normal	Abnormal
HEENT:	_____	_____
Hearing:	_____	_____
Thorax:	_____	_____
Heart:	_____	_____
Lungs:	_____	_____
Abdomen/GL	_____	Hernia: Y ____ N ____ Location _____
Genito-Urinary	_____	_____
Neurological:	_____	_____
Extremities:	_____	_____
Upper:	_____	_____
Lower:	_____	_____
Spine:	_____	_____

Lab: Urine: Spec. Gr.: _____ Alb._____ Sugar_____ Drug Screen Performed? ____Y ____N

Other Lab Findings: _____

General Comments: _____

_____

_____

_____

_____

Employability:

- ❑ Medically qualified - No restrictions
- ❑ Medically qualified with restrictions
- ❑ Medically recommend only after correction or control of condition or defect
- ❑ Recommendation is held pending further evaluation or records

Signature: _____