Pre-Employment History and Physical Form

Company: _____

Please note: "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family members of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member of an embryo lawfully held by an individual or family member receiving assistive reproductive services".

Personal Data:

Name:		Date of Birth:
Marital Status (circle): Single Married Widowed Divorced		Gender (circle): Male Female
Address:	City:	State:
Home Phone:	Mobile Phone:	

Current Medical Provider:

Provider Name:	Contact Number:

Review of Symptoms:

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
Weight loss/Weight gain (circle)			Heart palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision/wear lenses or glasses			Abdominal pain		
Dizziness/vertigo			Diarrhea/constipation		
Difficulty hearing			Irregular periods		
Seasonal allergies			Kidney stones		
Sinus problems			Back pain		
Tiredness or falling asleep during the day			Joint pain or swelling		
Unable to tolerate heat or cold			History of broken bones		
Shortness of breath with or without exertion			Swelling of the legs		
Wheezing			Skin problems (rash, eczema, psoriasis)		
Cough			Depression/anxiety		
History of tuberculosis					

Vaccinations:

Have you had	Yes	No	Unsure
The standard series of childhood vaccinations (to the best of your knowledge)?			
The disease chicken pox or the chicken pox vaccine?			

Have you had	Yes	No	Unsure
A tetanus/diphtheria booster shot within the last 10 years?			
Hepatitis B vaccinations (3 dose series)?			

Past Medical Conditions & Childhood Diseases: List those conditions that you have had in the past but have recovered from (such as childhood asthma, chicken pox, rheumatic fever, gestational diabetes).

Please List		Date (year)	Please List		Date (year)
1			4		
2			5		
3			6		

Past Surgeries/Hospitalizations: List the type of surgery or the condition for which you were hospitalized.

Please List		Date (year)	Please List		Date (year)
1			4		
2			5		
3			6		

Current Medical Conditions: List those that you are currently receiving treatment for such as diabetes, high blood pressure.

Please List		Date of onset (mo/yr)	Please List		Date of onset (mo/yr)
1			4		
2			5		
3			6		

Current Medications: Please include prescription and non-prescription medications such as vitamins, herbs.

1		5	
2		6	
3		7	
4		8	

Allergies: Please list any allergies to medications or other substances such as latex, food allergies.

1		5	
2		6	
3		7	
4		8	

Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to perform your job? (circle) Yes No If yes, please explain: _____

_____

I have read the above and declare that I have had no injury, illness, or ailment other than as specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

Applicant Signature: _____ Date: _____

Physical Examination (To be completed by the Provider):

Name: _____ Date of Birth: _____

Vital Signs:

Height	Weight	BMI	Blood Pressure	Pulse	O2 Sat	Respirations	Temperature

Vision:		
Acuity	**Uncorrected**	**Corrected**
Right Eye	20 /	20 /
Left Eye	20 /	20 /
Both Eyes	20 /	20 /
Color Blindness: ☐ Yes ☐ No		

Urinalysis: Completed N/A
Color:
Specific Gravity:
Protein:
Blood:
Sugar:

Hearing:	
Forced Whisper Test	
Right Ear	feet
Left Ear	feet
Hearing Aides used: Yes No	

Physical Exam:

System	Normal	Abnormal
General Appearance		
HEENT		
Neck		
Heart		
Lungs and Chest		
Abdomen		
Vascular System		
Genito-urinary System		
Extremities		
Musculoskeletal		
Neurological		
Skin		

Assessment Notes:

_____

_____

_____

_____

Physical Examination Result Status (To be completed by the Provider):

Name: _____ Date of Birth: _____

I have examined the above named individual who has been given a conditional offer of employment and I have found:

	No Work Restrictions—Medically qualified to perform all necessary job functions under the indicated working conditions and environment.
	Restricted—Medically qualified to perform all necessary job functions under the indicated working conditions and environment, provided the restrictions listed below can be accommodated and/or the recommendations listed below can be satisfied: _____ _____
	Not Medically Qualified—Not medically qualified to perform all necessary job functions under the indicated working conditions and environment for which he/she has been examined. Reasons are listed here: _____ _____
	Determination Pending (*specify reason*): _____ Return to medical exam office for follow up by (*within 45 days or less*): _____ Medical Examination Report amended (*specify reason*): _____ (if amended) **Medical Examiner's Signature**: _____ **Date:** _____

Provider Signature: _____ Date: _____

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