COMPANY NAME: ____________________

REPORT OF PHYSICAL EXAMINATION
TO BE COMPLETED BY JOB APPLICANT

NAME: ____________________ AGE: _____ DATE: __________ JOB TITLE: ____________________

PAST & PRESENT HISTORY: Have you ever in your PAST life had, or do you at PRESENT have? (Check all that apply)

	Past	Present	No		Past	Present	No		Past	Present	No
1. Allergy	☐	☐	☐	15. Ear trouble	☐	☐	☐	29. Nervousness	☐	☐	☐
2. Anemia/blood disorder	☐	☐	☐	16. Epilepsy	☐	☐	☐	30. Painful/difficult urination	☐	☐	☐
3. Any bone/ joint problem	☐	☐	☐	17. Eye trouble	☐	☐	☐	31. Paralysis	☐	☐	☐
4. Arthritis/Rheumatism	☐	☐	☐	18. Fainting spells	☐	☐	☐	32. Rheumatic fever	☐	☐	☐
5. Asthma/Hay fever/hives	☐	☐	☐	19. Headache/frequent	☐	☐	☐	33. Hernia/rupture	☐	☐	☐
6. Back trouble	☐	☐	☐	20. Head/spinal injuries	☐	☐	☐	34. Shortness of breath	☐	☐	☐
7. Bladder/kidney disease	☐	☐	☐	21. Heart disease/chest pain	☐	☐	☐	35. Pneumonia	☐	☐	☐
8. Bleeding/blood disorder	☐	☐	☐	22. Hemorrhoids	☐	☐	☐	36. Skin disease	☐	☐	☐
9. Breathing problems	☐	☐	☐	23. High blood pressure	☐	☐	☐	37. Sores that won't heal	☐	☐	☐
10. Broken/diseased bones	☐	☐	☐	24. Jaundice	☐	☐	☐	38. Stomach trouble	☐	☐	☐
11. Cancer	☐	☐	☐	25. Lung disease	☐	☐	☐	39. Stroke	☐	☐	☐
12. Tumor	☐	☐	☐	26. Knee/ankle injury	☐	☐	☐	40. Swelling of feet/joints	☐	☐	☐
13. Diabetes	☐	☐	☐	27. Mental disorder	☐	☐	☐	41. Tuberculosis	☐	☐	☐
14. Dislocation/Sprains	☐	☐	☐	28. Neck	☐	☐	☐	42. Venereal disease	☐	☐	☐
								43. Varicose veins	☐	☐	☐

Explain all "Past" & "Present" answers to above, using additional blank sheet of paper, if necessary. (Enter applicable item number before each comment):

____

____

____

____

44. Have you ever had, or been advised to have, an operation (includes tonsillectomy)? YES _____ NO _____
45. Have you ever been hospitalized for any other illness? YES _____ NO _____
46. Are you taking any medicine or drugs now or do you have prescriptions for any medications now? YES _____ NO _____
47. Are you allergic to any serum, drug or medicine? YES _____ NO _____
48. Do you wear glasses or corrective lenses? YES _____ NO _____
49. Have you ever had pain and/or an injury to your back which prevented you from working or attending school for a day or more? YES _____ NO _____
50. Have you lost any time whatsoever from work or school due to illness or injury in the past two years? YES _____ NO _____
51. Have you ever filed a compensation claim or received benefits as a result of any industrial injury or disease? YES _____ NO _____
52. Do you receive a disability pension? YES _____ NO _____
53. Have you ever had any illness or injury other than those already noted? YES _____ NO _____
54. Have you had recent gain or loss of weight? YES _____ NO _____
55. Have you been vaccinated for Tetanus? YES _____ NO _____ Date: ________________
56. Have you been vaccinated for Small Pox? YES _____ NO _____ Date: ________________
57. When did you last have a physical examination? YES _____ NO _____ Date: ________________
58. When did you last have a chest X-ray? YES _____ NO _____ Date: ________________
59. Do you smoke tobacco? YES _____ NO _____ If yes, what form and how many per day? ____________________

I certify that I have reviewed and understand the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of my medical record for purposes of processing my application for this employment and I am aware that any material omitted for falsification is reason for discharge.

Signature: ____________________ SS# ____________________ Date: ________________