

## Pre-Employment / Job Placement Medical Questionnaire

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family Doctor \_\_\_\_\_ Company \_\_\_\_\_ Job applied for: \_\_\_\_\_

**\*\* TO BE COMPLETED BY PROSPECTIVE EMPLOYEE PRIOR to appointment**

<p><b>Do you ever have</b></p> <p>Reaction to medication ..... Y N</p> <p>Reaction to chemicals ..... Y N</p> <p>Skin rashes or eczema ..... Y N</p> <p><b>Have you EVER had</b></p> <p>Asthma ..... Y N</p> <p>Hay fever or allergies ..... Y N</p> <p>Shortness of breath w/walking ..... Y N</p> <p>Tightness in chest ..... Y N</p> <p>Tuberculosis ..... Y N</p> <p>Emphysema or COPD ..... Y N</p> <p>Problem working in dusty job ..... Y N</p> <p><b>Do you</b></p> <p>Smoke cigarettes ..... Y N</p> <p>    _____ pk/day x _____ years ..... Y N</p> <p>Use other form of tobacco ..... Y N</p> <p><b>Have you every had</b></p> <p>High blood pressure ..... Y N</p> <p>Heart problem ..... Y N</p> <p>Heart attack ..... Y N</p> <p>Heart surgery (bypass, stent) ... Y N</p> <p>Swelling in ankles..... Y N</p> <p>Fainting spells / passed out..... Y N</p> <p>Varicose veins ..... Y N</p> <p><b>Do you have</b></p> <p>Stomach ulcer ..... Y N</p> <p>Frequent nausea ..... Y N</p> <p>Frequent bowel trouble ..... Y N</p> <p>Frequent diarrhea ..... Y N</p> <p>Hernia ..... Y N</p>	<p><b>Have you EVER had:</b></p> <p>Fits or convulsions..... Y N</p> <p>Epilepsy or seizures..... Y N</p> <p>Paralysis..... Y N</p> <p>Numbness in hands or feet..... Y N</p> <p>Double vision..... Y N</p> <p>Severe or disabling headaches... Y N</p> <p>Dizzy spells..... Y N</p> <p>Nervous breakdown..... Y N</p> <p><b>Have you EVER had:</b></p> <p>Back pain for more than 1-2 days per month..... Y N</p> <p>Back injury..... Y N</p> <p>Back surgery..... Y N</p> <p>Ruptured or herniated disk ..... Y N</p> <p>Knee or hip surgery..... Y N</p> <p>Swollen joints..... Y N</p> <p>Dislocated shoulder..... Y N</p> <p>Rheumatism or arthritis..... Y N</p> <p>Fracture of bone..... Y N</p> <p><b>Do you use:</b></p> <p>Glasses or contacts for reading.. Y N</p> <p>Glasses or contacts for distance Y N</p> <p>Are you color blind..... Y N</p> <p><b>Did you EVER have:</b></p> <p>Ear surgery..... Y N</p> <p>Difficulty hearing..... Y N</p> <p>Any other ear trouble..... Y N</p> <p>Do you wear hearing aids..... Y N</p> <p>Ringing in ears ..... Y N</p>	<p><b>Have you EVER had:</b> Y N</p> <p>Blood in urine..... Y N</p> <p>Kidney trouble..... Y N</p> <p>Trouble with urination..... Y N</p> <p><b>Have you EVER had:</b> Y N</p> <p>Liver trouble..... Y N</p> <p>Hepatitis or jaundice..... Y N</p> <p><b>Do you have:</b> Y N</p> <p>Diabetes..... Y N</p> <p>Thyroid problem or goiter ..... Y N</p> <p>Cancer of any kind..... Y N</p> <p>Problem with anemia..... Y N</p> <p>Problem where you bleed easily.. Y N</p> <p><b>Have you ever:</b> Y N</p> <p>Been treated with radiation..... Y N</p> <p>Worked with radioactive material Y N</p> <p><b>Are or do you:</b> Y N</p> <p>Taking any medicine regularly ... Y N</p> <p>Using any illegal drugs..... Y N</p> <p>Use alcohol regularly..... Y N</p> <p>How much? _____ Y N</p> <p>How often? _____ Y N</p> <p><b>Have you ever had:</b> Y N</p> <p>Restriction of any kind at previous job ..... Y N</p> <p>Any medical condition aggravated by work or job?.... Y N</p> <p>Hepatitis shot series..... Y N</p> <p>Date of your last tetanus shot? _____</p>
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Explanation of ALL "Y" answers:

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I hereby declare the answers I have given above are accurate to the best of my knowledge:

X \_\_\_\_\_ Date \_\_\_\_\_

Physician Comments/Clarifications

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## Physician Pre-Employment / Pre-placement Examination

Name \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Ht \_\_\_\_\_ Wt \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP #1 - \_\_\_\_/\_\_\_\_ #2 - \_\_\_\_/\_\_\_\_

VISUAL ACUITY	Distance		Near	
Actual – uncorrected	Right 20 /	Left 20 /	Right 20 /	Left 20 /
Corrected	Right 20 /	Left 20 /	Right 20 /	Left 20 /

PHYSICAL EXAMINATION	Normal	Abnor mal	Not Examined	Explain any abnormalities by number	
1. Head					
2. Eyes – PERRL, EOMI					
3. Ears – TM's & canals normal					
4. Nose – patent w/o drainage					
5. Throat – clear					
6. Neck – NI ROM, supple, no bruits					
7. Lymph nodes – none palpable					
8. Thyroid – not enlgd or tender					
9. Skin – no rashes or icterus					
10. Lungs – clear					
11. Heart – RRR w/o murmur, no evidence of enlgmt					
12. Chest – no deformity or tenderness					
13. Abdomen – non-tender, no masses/organomegaly, no bruits					
14. Hernia – no umbil or inguinal					Additional Findings
15. Genitalia – normal for age					
16. Rectal – no hemorrhoids					
17. Upper Extrem – full ROM without pain, nl strength					
18. Lower Extrem – full ROM without pain, nl strength					
19. Back/Spine – ROM WNL, no palpable tenderness, no visible deformity					
20. Reflexes – symmetric & normal					
21. Psych – no obvious abnormality					

**After examination and review of history on reverse, my impression is:**  normal exam

Job description reviewed – no contraindications to employment in this job.

\_\_\_\_\_

**Recommendations:** \_\_\_\_\_

\_\_\_\_\_

Examining Provider \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* Unless you indicate otherwise, only the IMPRESSION and RECOMMENDATIONS from this visit will be released to your prospective employer. Please indicate below if you wish to release the entire report (front & back pages) to your employer.**

*I hereby indicate my wishes to have the Hutchinson Clinic and the Examining Provider release a full copy of this report to my employer (insert name of employer \_\_\_\_\_)*

Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_