

B. MEDICAL HISTORY: (To be filled out by applicant.)

ALLERGIES: _____

IMMUNIZATIONS: (state approximate dates)

Tetanus _____ Hepatitis B _____ Rubella _____ Mumps _____

SOCIAL HISTORY: (cigarette smoking, alcohol usage, drug usage) _____

CURRENT MEDICATIONS: (dosage, duration and reason for usage) _____

LIST ANY SERIOUS ILLNESS OR TRAUMATIC INJURY, HOSPITALIZATION, SURGERY, etc. _____

HAVE YOU ANY RESPIRATORY CONDITIONS OR SYMPTOMS? (asthma, shortness of breath, wheezing, chronic cough, etc.) _____

HAVE YOU ANY CARDIOVASCULAR SYMPTOMS? (high blood pressure, chest pain, murmurs, palpitations, dizziness, etc.) _____

HAVE YOU ANY JOINT/MUSCLE PAINS OR SWELLING; NECK/BACK PROBLEMS? _____

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, DIZZINESS, FAINTING OR SEIZURES? _____

HAVE YOU ANY MENTAL OR EMOTIONAL DISORDERS THAT YOU WISH TO INFORM US ABOUT, EITHER CURRENTLY OR IN THE PAST? _____

Applicant's Signature _____

Date _____

SECTION II: PHYSICAL EXAMINATION (To be completed by applicant's physician)

NAME: _____ **Soc. Sec. #:** _____

General Description: (including nutritional status, personal hygiene and noticeable aspects of personal appearance) _____

VITAL SIGNS: Pulse _____ Resp. _____ Temp. _____ BP _____ Ht. _____ Wt. _____

VISUAL ACUITY: **WOG:** right ____/____ left ____/____ **WG:** right ____/____ left ____/____

Check if WNL. If not, please comment.

{ } EYES: _____

{ } EARS: _____

{ } NOSE/THROAT: _____

{ } NECK: _____

{ } LUNGS: _____

{ } HEART: _____

{ } ABDOMEN: _____

{ } SPINE: _____

{ } EXTREMITIES/JOINTS: _____

{ } NEUROLOGIC: _____

IS APPLICANT **FREE** OF COMMUNICABLE DISEASE? Yes ____ No ____

ONGOING MEDICAL PROBLEMS: _____

MEDICAL RESTRICTIONS: (Explain) _____

IS APPLICANT MEDICALLY QUALIFIED TO WORK IN HIS/HER JOB TITLE? Yes ____ No ____

COMMENTS: _____

Physician's Signature: _____ Date _____

Print Name, Address and Telephone No.: _____
