Company	Name
Job Title	Address
☐ Post Offer ☐ Surveillance ☐ Dive ☐ No Fault ☐ Respirator ☐ DOT ☐ Fit for Duty ☐ Asbestos ☐ Hazmat ☐ _____	Home Phone No. / Birthdate Work Phone No. / Soc. Sec. No.

MEDICAL HISTORY: Have you ever had. . . (Please ✓ "YES" or "NO" and explain "YES" items below):

		Yes	No			Yes	No			Yes	No
1	Head injuries/Headaches			13	Heart Trouble			25	Carpal Tunnel Syndrome		
2	Seizures/Unconscious			14	High Blood Pressure			26	Paralysis, Weakness, Stroke		
3	Pregnancy now			15	Stomach Trouble			27	Back or Spinal Condition		
4	Persistent Headaches			16	Liver, Gall Bladder Trouble, Hepatitis			28	Permanent Defect from Illness or Injury		
5	Emotional, Nervous or Mental Disorder			17	Hemorrhoid / Blood in Stool			29	Extensive Confinement from Illness or Injury		
6	Eye Trouble, Poor Vision, Glaucoma			18	Hernia			30	Operations/Hospitalization		
7	Ear Trouble, Hole in Eardrum			19	Kidney or Bladder Disorder			31	Drug or Alcohol Abuse		
8	Persistent Cough			20	Venereal Disease, STD			32	Allergies (including medications)		
9	Pneumonia or Pleurisy			21	Muscular Disorder			33	Skin Trouble		
10	Shortness of Breath			22	Arthritis, Gout			34	Tumor, Cancer		
11	Asthma, Hay Fever			23	Diabetes			35	Chronic Fatigue		
12	Tuberculosis			24	Rheumatic Fever			36	Current Medications		

Explain: (List by number)

FAMILY HISTORY

		Yes	No			Yes	No			Yes	No
37	Heart Disease			39	Diabetes			41	Hereditary Disease		
38	Cancer			40	Tuberculosis			42	Other		

Explain: (List by number)

I have answered the above questions to the best of my knowledge. I hereby authorize the forwarding of the results of this History & Exam to my company.

SIGNATURE: **DATE:**

EXAMINATION & TESTS

43. HT (IN) _____ 44. WT (LB) _____ 45. BP _____ (at rest / after exercise) 46. P _____ 47. R _____ 48. T _____ 49. LMP _____

	50. Vision Uncorrected Far	Near	51. Vision Corr. Far	Near	52. Fields	53. Color	54. Depth
Right							
Left							
Both							

Glasses or Contacts: ☐ Yes ☐ No

55. Audiogram

	500	1000	2000	3000	4000	5000	6000
Right							
Left							

Hearing Aid: ☐ Yes ☐ No **56. Tympanogram:** L _____ R _____

Pulmonary Function Test

		Best of 3	Predicted			Best of 3	Predicted
58	FVC			60	FEV1/FVC		
59	FEV1			61	FEF 25-75%		

57. Urinalysis: Sugar _____ Albumin _____ Spec. Grav. _____

		NL	AB			NL	AB			NL	AB			NL	AB			NL	AB
62	General Appearance			67	Nose			72	Heart			77	Spine			82	Genitalia		
63	Skin			68	Mouth, Throat			73	Abdomen			78	Neurological			83	Scars, Markings		
64	Head			69	Neck			74	Hernia			79	Reflexes			84	Olfactory (Smell)		
65	Eyes			70	Chest, Lungs			75	Upper Extremities			80	Romberg			85	Psychiatric		
66	Ears			71	Breasts			76	Lower Extremities			81	Rectal/Anus			86			

REMARKS:

SUMMARY:

EXAMINER'S NAME:	**SIGNATURE:**	**DATE:**