NEW YORK UNIVERSITY
PRE EMPLOYMENT PHYSICAL

Human Resource Department only:

Name of HR Representative scheduling Exam:_____ Department:_____

Date Scheduled:_____ Job Type:_____

To Be Completed by Prospective Employee PRIOR TO APPT:

PRINT Last Name First Name Middle Initial Date

Address City State Zip Code Age Date of Birth

M F

Phone Number Sex

In Emergency Notify Relationship Phone Number

PLEASE COMPLETE THE FOLLOWING PRIOR TO SEEING PROVIDER - LEAVE NO BLANK SPACES:

	YES	NO	DON'T KNOW
Frequent Headaches			
Eye or Ear Infections			
Throat Trouble			
Sinus Trouble			
Thyroid Problems			
Frequent Colds			
Lumps or Tumors in Neck			
Asthma			
Pneumonia			
Pleurisy			
Spitting up Blood			
Coughing up Blood			
Chronic Cough			
Lung Trouble			
Tuberculosis			
Shortness of Breath			
Chest Pains			
Rheumatic Fever			
Heart Murmur			
Swelling of Ankles			
Low Blood Pressure			
Stomach Trouble			
Heartburn			
Vomiting Blood			
Black Bowel Movements			
Blood in Stools			
Frequent Diarrhea			
Abdominal Pains			
Gallbladder Trouble			
Liver Trouble			
Hepatitis or Jaundice			
Piles, Hemorrhoids			
Tropical Disease or Worms			
Hernia or Rupture			
Kidney Trouble			
Kidney Stones			
Blood in Urine			

	YES	NO	DON'T KNOW
Bladder Infections			
Frequent Urination			
Broken Bones			
Back Sprains or Surgery			
Arthritis			
Deformities of Joints			
Deformities of Bones			
Missing Fingers or Toes			
Ruptured Disc in Back			
Skin Rashes			
Skin Tumors			
Head Injury			
Epilepsy or Fits			
Frequent Dizziness			
Paralysis			
Loss of Memory			
Diabetes or High Sugar			
Sugar in Urine			
Allergies			
Allergic reaction to food			
Allergic reaction to Drugs			
Anemia			
Polio			
Recent Weight Loss			
Recent Weight Gain			
Fatigue			
Depression			
Anxiety or Panic Attacks			
Change in Activity Level			
High Blood Pressure			
Chronic Bronchitis			
Muscle Pain			
Sleeping Problems			
Breast Lumps			
Loss of Consciousness			
Excessive Thirst			

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NAME:_____

Have you ever:	YES	NO
Suffered from hearing problems or hearing loss		
Suffered from visual problems or eye diseases		
Had back problems, back pain or back injuries		
Had foot problems		

Have you ever been a patient in a hospital for any reason? YES NO
If YES, please complete the following section:

	NAME OF HOSPITAL	CONDITION TREATED FOR	DATES
1			
2			
3			
4			
5			
6			
7			
8			

Have you ever lost time from work in the past year for ANY REASON? YES NO
If YES, Please explain: _____

Are you currently uder the treatment or care of a physician, Nurse Practitioner or other health care provider in the past year?
If YES, Please explain: _____

Do you SMOKE? YES NO
If YES - What do you smoke?_____ How many per day?_____ How many years?_____

Do you drink ALCOHOL? YES NO
If YES - How many drinks do you drink at each sitting?_____ How many days per week?_____
What do you drink? BEER WINE HARD LIQUOR OTHER:_____

Are you taking prescribed or over the counter medications, herbal products, vitamins or supplements?

MALES ONLY:
Have you now or have you ever had a HERNIA or RUPTURE OF A HERNIA? YES NO
Have you ever had a Sexually Transmitted Disease? Gonorrhea Syphilis Chlamydia
Have you ever had problems with your testicles (surgery, infection, injury)? YES NO

FEMALES ONLY:
Have you now or have you ever had any problems with your breasts (lumps, tumors, surgery)? YES NO
Are you now or have you ever been pregnant? YES NO If YES, how many pregnancies?_____ Miscarriages?_____
Are your periods regular? YES NO Do you have pain with your periods? YES NO Date of Last Period_____
Have you ever had a Sexually Transmitted Disease? Gonorrhea Syphilis

NEW YORK UNIVERSITY
PRE EMPLOYMENT PHYSICAL

NAME:_____

VACCINATION HISTORY:
Last known Tuberculin Skin Test? _____ Results: Negative Positive - If positive was a Chest X ray done? YES NO
If YES - Results of Chest x ray?_____

Last Tetanus Shot_____ Hepatitis B Vaccination YES NO If YES, when?_____

What is your private healthcare providers name? _____
Address: _____
Phone number: _____

I give permission to the screening healthcare provider at New York University Health Center to forward any abnormal findings to my healthcare provider. I understand that I am responsible for following up with my own healthcare provider on any abnormal findings that arise during the pre-employment physical conducted by the healthcare screening provider at NYU. I understand that NYU will not provide follow-up treatment for such findings.

PRINT NAME _____ SIGNATURE _____ DATE _____

The information contained in this form is of a strictly confidential nature. The form will remain in the New York University Health Center confidential files and may be seen only by the examining healthcare provider, nurses in attendance and administrative personnel reviewing the chart for quality assurance reasons. I hereby declare the answers I have given are to the best of my knowledge.

PRINT NAME _____ SIGNATURE _____ DATE _____

TO BE COMPLETED BY UHC PROVIDER:

NEW YORK UNIVERSITY HEALTH CENTER
PRIMARY CARE SERVICE PROVIDER

VITAL SIGNS: BP_____ HR_____ HEIGHT:_____ WEIGHT:_____

VISUAL ACUITY WITH WITHOUT CORRECTION:
RIGHT EYE 20/
LEFT EYE 20/
BOTH EYES 20/

GENERAL APPEARANCE: NEAT POOR HYGIENE OBESE THIN AVERAGE

PPD IMPLANT DATE:_____ SITE:_____
PPD READING DATE:_____ NEGATIVE _____ MM INDURATION
POSITIVE _____ MM INDURATION

CXR DATE:_____
CLEARED/XRAY NORMAL
NOT CLEARED - REFER TO PMD

LAB DATA:

HGG:_____ HCT:_____ WBC:_____

URINE: SUGAR:_____ ACETONE:_____ ALBUMIN:_____

SEROLOGY / RPR:_____

NEW YORK UNIVERSITY
PRE EMPLOYMENT PHYSICAL

NAME:_____

GENERAL APPEARANCE: NEAT POOR HYGIENE OBESE THIN AVERAGE DISTRESS NO DISTRESS

NORMAL	SYSTEM	ABNORMAL WITH COMMENTS:
	HEAD	
	EYES	
	EARS	
	NOSE	
	MOUTH	
	NECK	
	CHEST	
	BREASTS	
	HEART	
	LUNGS	
	ABDOMEN	
	RECTAL	DEFERRED (circle if deferred)
	GENITALIA	DEFERRED (circle if deferred)
	EXTREMITIES	
	SPINE	
	NEURO	
	SKIN	
	PSYCH	

ADDITIONAL FINDINGS: _____

FOLLOW UP REQUIRED: _____

_____ _____ DATE:_____

EXAMINING PROVIDER (PRINT) EXAMINING PROVIDER SIGNATURE