Axiom Medical Consulting, LLC | **PHYSICAL EXAMINATION** | **Medical Confidential**

Name (Last, First)				Social Security Number	Today's Date
Birthdate	Age	Sex	Race	Program and Base Location	
Home Phone		Work Phone		Job Title or Assignment	

Home Address (Street, City, State and Zip Code)

Employee Number:

Date of hire:

Vital Signs

Weight (lbs) _____ Height _____ ft _____ in. Temperature _____ Pulse _____ Blood Pressure _____ BP Repeat _____

Vision Uncorrected: OD 20/____ OS 20/____ OU 20/____ Far — Corrected: OD 20/____ OS 20/____ OU 20/____ Far

Color Test results: ☐ Not done ☐ Fail blue/yellow ☐ Pass ☐ Fail red/green

Urinalysis

Sp. Gr. _____ Blood _____ Protein _____ Sugar _____

Horizontal visual field (degrees) Right _____ Left _____ Total _____

Hearing		500	1000.	2000	3000	4000	6000	8000
Protection ☐ Yes ☐ No	Right							
Protection type ☐ Plugs ☐ Muffs	Left							

☐ ☐ _____ _____

Examination (check one box for each category - explain abnormalities in comments)

		N	ABN	NE	Comments
1	Skin				
2	Eyes				
3	Ears				
4	Nose				
5	Mouth and throat				
6	Neck including thyroid				
7	Chest including breast				
8	Lungs				
9	Heart				
10	Abdomen				
11	Genitalia				
12	Anus and rectum				
13	Prostate				
14	Back and extremities				
15	Neurologic				
16	Other (explain)				

General state of health

Diagnosis

List any physical limitations or impairments

Examiner's Name (type or print)	**Examiner's Signature**	**Date**

* Attach copy of reports. Do not send chest films.

Axiom Medical Consulting, LLC **MEDICAL HISTORY** **Medical Confidential**

Name (Last, First)				Social Security Number	Today's Date
Birthdate	Age	Sex	Race	Work Location	
Home Phone		Work Phone		Job Title or Assignment	

Home Address (Street, City, State and Zip Code)

Examination Type (check appropriate box)

☐ Safety Sensitive ☐ HAZWOPER ☐ Audiogram ☐ Respirator ☐ Other (list type) _____

If you currently have the medical condition listed below check 'Now'. If you had it in the past check 'Past'. If you never had the condition leave it blank.

Now	Past	Patient History
☐	☐	1. Have you been turned down for a job, for the armed services, or for insurance because of health or because of a physical examination
☐	☐	2. Have a physical or health problem
☐	☐	3. Have received Workers' Compensation
☐	☐	4. Have allergies (specify). _____
☐	☐	5. If current or former alcohol drinker, list number of drinks consumed in the average week _____
☐	☐	6. Average number of cigarettes smoked each day (now or in past) _____
☐	☐	7. Have had surgery (specify and enter date of surgery) _____
☐	☐	8. Have had a major or serious non-occupational injury or illness (specify) _____
☐	☐	9. Prescription medication use (specify) _____
☐	☐	10. Non-prescription medication use (specify) _____
☐	☐	11. Any eye illness (i.e., cataracts, glaucoma, etc.) _____
☐	☐	12. Loss of hearing
☐	☐	13. Any ear illness (i.e., ringing, buzzing, etc.) (specify) _____
☐	☐	14. Respiratory (lung) diease (i.e., pneumonia, bronchitis, pleurisy, TB, etc. _____
☐	☐	15. Hypertension (high blood pressure)
☐	☐	16. Any heart disease (i.e., chest pain, heart failure, heart attack, etc.) _____
☐	☐	17. Any circulatory problems (i.e., cramps in legs when walking, varicose veins, stroke, etc.) _____
☐	☐	18. Recurrent or persistent pain or stiffness in back, including neck
☐	☐	19. Bone, joint, or muscle problems, including amputations and fractures (specify) _____
☐	☐	20. Hernia
☐	☐	21. Any gastrointestinal disease (i.e., ulcer, colitis, blood in bowel movement, etc.) _____
☐	☐	22. Any kidney or bladder disease
☐	☐	23. Recurrent headaches
☐	☐	24. Epilepsy (convulsions, seizures)
☐	☐	25. Mental or emotional disease
☐	☐	26. Neurological disease (specify) _____
☐	☐	27. Endocrine or metabolic disorder (i.e., gland, diabetes, etc.) _____
☐	☐	28. Any blood disease (i.e., anemia, leukemia, clotting problem, etc.) _____
☐	☐	29. Any skin disease (specify) _____
☐	☐	30. Infection of uterine tube, pelvic inflammatory disease (specify) _____
☐	☐	31. Pregnant
☐	☐	32. Other abnormal findings or diseases not covered elsewhere in this questionnaire (specify) _____

Additional space for comments

I certify that all my responses are true to the best of my knowledge.	Patient Signature	Date

Axiom Medical Consulting, LLC

PHYSICIAN'S WRITTEN OPINION

Name (Last, First)	Social Security Number	Today's Date

Examination(s) Performed: *The citations below refer to the Occupational Safety and Health Standards for General Industry (29 CFR 1910)*

- ☐ Acrylonitrite (1910.1045)
- ☐ Arsenic (1910.1018)
- ☐ Asbestos (1910.1001)
- ☐ Audiogram - hearing (1910.95)
- ☐ Benzene (1910.1028)
- ☐ Cadmium (1910.1027)
- ☐ Chromium (1910.1026)
- ☐ DOT - FMCSA (driver) (49 CFR Part 391)
- ☐ Fire Brigade
- ☐ Formaldehyde (1910.1048)
- ☐ HAZWOPER (1910.120)
- ☐ HazMat (1910.120)
- ☐ Lead (1910.1025)
- ☐ Respirator (1910.134)
- ☐ Other (specify) _____

You have the following medical conditions which may place you at greater than normal risk from the exposures checked above:

☐ None

Specify _____

You require the following restrictions on work, on exposures at work, or on the use of personal protective equipment:

☐ None

Specify _____

Further medical evaluation is recommended as follows:

☐ None

Specify _____

The above employee has been informed of the results of his/her medical evaluation and of any conditions which may have resulted from the alleged occupational exposure(s) which require further explanation or treatment.

Physician's Signature	Date of Signature		
Physician's Printed Name	Telephone		
Physician's Address	City	State	Zip

Employee's Signature	Date of Signature