OSF
ST. JOSEPH
MEDICAL CENTER

MEDICAL EXAMINATION FORM

FIRST LAST MIDDLE **Name**	TIME
CITY STATE / ZIP CODE **Address**	DATE OF SERVICE
DAY EVENING **Phone** **SSN**	RELIGION
Sex ☐ Male ☐ Female **Date of Birth (m/d/y)**	PRESENT AGE
Family Doctor's Name	PHONE
ADDRESS CITY STATE/ZIP CODE	HEALTH INSURANCE
Employer	PHONE
CITY STATE / ZIP CODE **Address**	START DATE
Position Applied For	

Have you had any operations/hospitalizations/surgery? (If YES, list with dates) **Date:**

☐ Yes ☐ No _____

_____

_____

Have you ever had a *work* injury or illness? (If YES, provide details) **Date:**

☐ Yes ☐ No _____

_____

_____

PREVIOUS OCCUPATIONAL HISTORY

Please check the number of years you have had Substantial exposure to:			NUMBER OF YEARS	
1. Noise (machines, guns, loud music, etc)	1. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
2. Metal fumes or dust (welding, soldering, etc)	2. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
3. Heavy metal (cadmium, chromium, mercury, lead, arsenic)	3. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
4. Other dust (mining, wood dust, etc)	4. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
5. Paints and dyes	5. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
6. Pesticides, etc	6. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
7. Solvents (cleaning, degreasing, etc)	7. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
8. Petroleum products (cutting oils, lubricants, etc)	8. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
9. Other chemicals (adhesives, plastics, foams, etc)	9. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
10. Sterilizing agents (ethylene oxide, etc)	10. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
11. Smoke / Exhaust fumes	11. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
12. Acrylonitrile	12. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
13. Benzene	13. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
14. Nickel	14. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
15. Isocyanates	15. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
16. Silica	16. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
17. Vinyl Chloride	17. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
18. Formaldehyde	18. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
19. Cotton Dust	19. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
20. DBCP	20. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
21. Glutaraldehyde	21. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs
22. Any other: _____	22. ☐ 0	☐ < 1 yr	☐ 1-5 yrs	☐ > 5 yrs

Description of work or activity where exposure occurred: _____

Have you been treated by a physician (or osteopath, chiropractor or other) during the last five years? □ Yes □ No
What was the treatment for and approximate dates and duration of treatment: _____
_____

Have you ever been seriously injured or burned? □ Yes □ No Year:
Nature of injury: _____ **Outcome of Injury:** _____
Have you ever had any trouble with your back? □ Yes □ No Year:
Nature of injury: _____ **Outcome of Injury:** _____
Have you ever had any trouble with your shoulders? □ Yes □ No Year:
Nature of injury: _____ **Outcome of Injury:** _____
Have you ever had any trouble with carpal tunnel? □ Yes □ No Year:
Nature of injury: _____ **Outcome of Injury:** _____
Have you ever had trouble with cubital tunnel syndrome? □ Yes □ No Year:
Nature of injury: _____ **Outcome of Injury:** _____

Disease of:	Yes	No	Disease of:	Yes	No	Disease of:	Yes	No	Disease of:	Yes	No
Brain			Genitals			Chronic Constipation			Rheumatic Fever		
Eyes			Dizziness			Black or Bloody Stools			Paralysis		
Ears			Frequent Headaches			Frequent/Painful Urination			Caner or Tumors		
Nose			Deafness			Blood in Urine			Asthma		
Throat			Frequent Sore Throat			Swollen Ankles			Hay Fever		
Heart			Frequent Colds			High Blood Pressure			Diabetes		
Lungs			Fainting Spells			Jaundice			Arthritis		
Stomach			Chest Pains			Hernia (rupture)			Rheumatism		
Intestines			Shortness of Breath			Stomach Ulcers			Nervous Breakdown		
Liver			Chronic Cough			Pneumonia			Foot Problems		
Spleen			Coughing up Blood			Pleurisy			Backaches		
Gall Bladder			Palpitations			Kidney Stones			Chronic Sinus Infect		
Kidneys			Poor Appetite			Hemorrhoids			Injuries		
Bladder			Chronic Indigestion			Convulsions/Seizures			Operations		
Bone			Recurrent Nausea			Tuberculosis			Malaria		
Joints			Recurrent Vomiting			Bronchitis			Lymph Nodes		
Back (Spine)			Vomiting of Blood			Nephritis			Other Serious Illness		
Skin									Past Salmonella Infection		

DETAILS OF DISEASE:_____
_____
_____

Have you had any serious illness or accident not referred to previously on this form? □ Yes □ No
If yes, please give dates and details. _____
_____
_____

Immunizations / Disease you have had:

	APPROX. YEAR		APPROX. YEAR
□ Yes □ No Tetanus		□ Yes □ No Measles (Rubeola)	
□ Yes □ No Polio		□ Yes □ No German Measles (Rubella)	
□ Yes □ No Hepatitis A		□ Yes □ No Chicken Pox (Varicella)	
□ Yes □ No Hepatitis B			

Allergies:

	List:
□ Yes □ No Medication	
□ Yes □ No Environmental	
□ Yes □ No Latex	

Medications

	List:
□ Yes □ No Do you use herbal / nutritional suppliments?	
□ Yes □ No Do you use over the counter medications?	
□ Yes □ No Do you use prescription medications?	

Personal History

Are you under medical care at this present time? If yes, Doctor's Name: _____
□ Yes □ No
Reason_____
_____

Do you currently smoke? □ Yes □ No
If YES, how many packs per day? _____ For how long? _____

Did you ever smoke? □ Yes □ No If Yes, when did you quit? _____
If YES, how many packs per day? _____ For how long? _____

Do you currently chew tobacco? □ Yes □ No
If YES, how much? _____ For how long? _____

Did you ever chew tobacco? □ Yes □ No If Yes, when did you quit? _____
If YES, how much? _____ For how long? _____

Do you have any nutritional concerns? □ Yes □ No

Is there any cultural/personal/religious beliefs that need to be considered in your care or taking of medications which we may prescribe? □ Yes □ No

FEMALES ONLY

Date of last normal menstrual period: _____

Are you pregnant? □ Yes □ No

I THE UNDERSIGNED, DO HEREBY CERTIFY THE ANSWERS TO THE ABOVE QUESTIONS ARE CORRECT. I UNDERSTAND THAT THIS IS A CONFIDENTIAL DOCUMENT. I UNDERSTAND THAT FALSIFICATION, MISREPRESENTATION OR OMISSION OF THE INFORMATION MAY RESULT IN DISCHARGE REGARDLESS OF WHEN DISCERNED.

Employee Signature: _____ Date: _____

Reviewed Date: _____ Initials: _____

PHYSICAL FINDINGS

Name **SS #** **Date**

Height	Weight	Temp	Pulse	BP	Respirations
Urinalysis/Dipstick	Specific Gravity	Protein	Glucose	Blood	Other

Audiological Testing

	Thresholds Left ear	Right ear
500 Hz		
1000 Hz		
2000 Hz		
3000 Hz		
4000 Hz		
6000 Hz		
8000 Hz		

Test Performed by: _____

Vision Testing

Vision Screener: **Contacts or Glasses:**

	Far	Near
Both Eyes	20 / _____	
Right	20 / _____	
Left	20 / _____	

Stereo Depth _____

Color
Ishihara
 # correct _____
Total _____
R G A
Other

Peripheral Vision

Right Temporal	85'	75'	55'	Nasal 45'
Left Temporal	85'	75'	55'	Nasal 45'

Physical

Check (✓) under N if Normal or AB if Abnormal. NE if not examined. Give details of abnormal findings below.

	N	AB	NE		N	AB	NE		N	AB	NE
General Appearance				Pharynx (including tonsils)				External Genitalia			
Hygiene				Neck (including thyroid)				Rectum & Anal Region			
Skin (including scalp)				Breasts				Spine			
Eyes				Lungs				Joints & Extremities			
Ears, External				Heart				Scars			
Ears, Drums & Canals				Peripheral Pulses				Varicose Veins			
Nose				Abdomen				Lymph Glands			
Mouth (teeth & gums)				Hernia				Neurological			

Physician's Note on History: _____

_____

_____

_____

Physician's Note on Abnormal Findings: _____

_____

_____

_____

Medical Assessment

- ☐ Recommended for placement without restrictions for: _____
- ☐ Recommended for placement pending tests: _____
- ☐ Recommended for placement with the following restriction(s) / limitation(s): _____
- ☐ Recommended placement be deferred. Re-evaluate: _____ (days, weeks, months, year)
- ☐ Not recommended for placement.
- ☐ Recommended follow-up with family physician
- ☐ On Hold (Specify reason): _____

_____ DATE

_____ PROVIDER'S SIGNATURE

_____ PRINT NAME