NORTHSIDE
FAMILY MEDICINE &
URGENT CARE

PRE-EMPLOYMENT PHYSICAL - INALFA

Patient Name _____ Date of Birth _____

Please Circle: **Gender** Male Female **Marital Status:** Single Married Divorced Widowed

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Language _____ Ethnicity _____ Race _____

Email Address _____

REVIEW OF SYSTEMS

Do you have any of the following?	Yes	No		Yes	No
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest Pain or tightness		
Headaches			Indigestion / Heartburn		
Difficulty with vision / Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea / Constipation		
Seasonal allergies			Irregular periods		
Sinus problems			Kidney Stones		
Tiredness or falling asleep during the day			Back pain		
Unable to tolerate heat or cold			Joint pain or swelling		
Shortness of breath with or without exertion			History of broken bones		
Asthma			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		
Bronchitis			High Blood Pressure		
Emphysema			Diabetes		
Sneezing			Depression, Anxiety		
Nose Bleeds			Epilepsy or other Seizure Disorders		
Allergies			Fainting spells		
Carpal Tunnel Syndrome			Hepatitis, Cirrhosis, or other Liver Disease		
Loss of memory			Jaundice		
History of Tuberculosis			Sleep Disorders		

Last Tetanus Shot: _____ Hepatitis B Vaccination: Yes No If Yes, when? _____

Do you Smoke? Yes No If Yes, what do you smoke? _____ How many per day? _____

Do you drink Alcohol? Yes No If Yes, what do you drink? _____ How much do you drink? _____

Do you use illicit/illegal drugs? Yes No _____

Current Medical Conditions (Please list those that you are currently receiving treatment for. Date of onset, month and year)

_____

_____

_____

Do you have allergies to any medications or other substances? Yes No If yes, please specify: _____

_____

_____

-continued-

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Name:_____ MR#_____

Please list prescribed medications and over the counter medications that you take:_____

_____

_____

_____

Have you ever lost time from work in the past year for any reason? Yes No If yes, please explain:_____

_____

Have you ever been hospitalized? Yes No If yes, please explain: _____

_____

Have you ever had surgery? Yes No If yes, please explain: _____

_____

Are you currently under the treatment or care of a physician or other health care provider? _____

_____

Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to preform your job? Yes____ No____ If yes, explain:_____

_____

The above answers are true and correct to the best of my knowledge and belief. I understand that falsification may be grounds for termination. This also authorizes release of any medical information, concerning my past or present condition pertinent to my employment, by the physician and staff administering this examination.

Applicant's Signature_____ Date: _____

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PHYSICAL EXAMINATION - INALFA

PATIENT NAME: _____ DATE:_____ MR# _____

VITAL SIGNS

BP _____ HR _____ SpO2 _____ TEMP _____ HEIGHT _____ WEIGHT _____

VISION: Uncorrected / Corrected: Right Eye: _____ /_____ Left Eye: _____ /_____ Both Eyes: _____ /_____

Visual Fields: Rt. Eye: _____ Lt. Eye: _____ Color: Normal Abnormal Depth Perception: Normal Abnormal

		NORMAL		ABNORMAL FINDINGS
HENNT:				
Eyes –	Globe	_____		_____
	Pupils	_____		_____
	EOM's	_____		_____
Ears –	Canal Clear	Yes	No	
	TM Visualized	Yes	No	
	Scarring of TM	Yes	No	
	Drainage	Yes	No	
Mouth –	Teeth	_____		_____
	Throat	_____		_____
NECK:		_____		_____
THYROID:		_____		_____
CHEST/LUNGS:		_____		_____
HEART:	Rhythm	_____		_____
	Auscultation	_____		_____
SKIN:		_____		_____
ABDOMEN:		_____		_____
HERNIA –	Umbilical	No	Yes	
	Inguinal	No	Yes	
	Femoral	No	Yes	
VARICOCELE:		No	Yes	
NEUROLOGICAL:		_____		_____

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PHYSICAL EXAMINATION - continued

Name:_____ MR#_____

	NORMAL	ABNORMAL FINDINGS
MUSCULOSKELETAL:	_____	_____
Upper Extrem. Strength	_____	_____
Upper Extrem. ROM	_____	_____
Lower Extrem. Strength	_____	_____
Lower Extrem. ROM	_____	_____
Back/Spine ROM	_____	_____

OTHER: _____

_____

LIFT TEST: Weight_____ lbs _____

DRUG SCREEN RESULTS: _____

ASSESSMENT: _____

_____

_____

_____

Cleared without limitation: _____

Cleared with restrictions: _____

Cleared after completing evaluation: _____

Referred to: _____

Signature of Physician/Physician Assistant/Nurse Practitioner: _____

Print Name _____ DATE:_____

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Drug Screening Authorization / Results
5 Panel Instant Drug Screen

MR# _____

Last Name: _____ First Name: _____

SS#: _____ Date of Birth: _____ Phone: _____

Donor ID Verified: _____ Photo ID _____ Employment Rep. _____

I agree to submit to a drug screening test and give my consent for all information obtained as a result of this test to be released to the company. I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; and the specimen bottle used was sealed with a tamper-evident seal in my presence. That the information and numbers provided on this form and the label affixed to the bottle is correct.

Donor's Signature _____ Date & Time: _____

SCREEN RESULTS ("POSITIVE" results must be confirmed by a laboratory.)

Time Collected: _____ Time Interpreted: _____

Temperature between 90 - 100 degrees F? _____Yes _____No
(This test must be read within 3-5 minutes of collection.

Test	**Negative**	**Positive**
AMP (Amphetamine)	_____	_____
mAMP (Methamphetamine)	_____	_____
COC (Cocaine)	_____	_____
THC (Marijuana)	_____	_____
OPI (Opiates)	_____	_____

Collector's Signature _____ Date & Time: _____

MEDICAL REVIEW OFFICER:
In accordance with applicable requirements, my determination/verification is:

_____Negative _____Positive _____Test Cancelled _____Refusal to test because:

MRO Name: _____ MRO Signature: _____