

NORTHSIDE
FAMILY MEDICINE &
URGENT CARE
HOLLY SPRINGS

PRE-EMPLOYMENT PHYSICAL

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

<i>Do you have any of the following?</i>	Yes	No		Yes	
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		
Sneezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		
Allergies			High Blood Pressure		
Carpal Tunnel Syndrome			Diabetes		
Loss of memory			Depression, Anxiety		
History of Tuberculosis					

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: _____

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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: _____

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 perform your job? Yes ___ No ___ If yes, explain: _____

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PHYSICAL EXAMINATION

PATIENT NAME: _____ DATE: _____ MR# _____

VITAL SIGNS

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

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

NORMAL ABNORMAL FINDINGS

HENNT: _____

NECK: _____

CHEST/LUNGS: _____

HEART: _____

ABDOMEN: _____

MUSCULOSKELETAL: _____

NEUROLOGICAL: _____

SKIN: _____

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: _____