Pre-Employment Physical Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____
Primary Physician: _____ Phone: _____
Insurance Provider: _____ ID No. _____

Employment

Job Title: _____ Department: _____ EIN: _____
Previous Employer: _____ Dates: _____
Previous Employer: _____ Dates: _____

Current Symptoms (Check All That Apply)

☐ Headaches	☐ Joint Pain/Swelling	☐ Dizziness	☐ Numbness
☐ Nausea	☐ Vision Impairment	☐ Hearing Impairment	☐ Weight Loss/Gain
☐ Fevers	☐ Coughing/Wheezing	☐ Fatigue	☐ Chest/Back Pain

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Smoking Frequency: _____ Drinking Frequency: _____
Illicit Drug Frequency: _____ Fast Food Frequency: _____
Allergies: _____
Current Medications: _____
Current Diagnoses: _____
Current Injuries: _____
Previous Injuries: _____
Previous Medications: _____
Dates Treated: _____
Previous Medical Conditions: _____
Previous Surgeries: _____

Vaccinations

Standard Childhood Vaccinations	☐ Yes ☐ No	Date:	_____
Hepatitis A	☐ Yes ☐ No	Date:	_____
Hepatitis B	☐ Yes ☐ No	Date:	_____
Tuberculosis	☐ Yes ☐ No	Date:	_____
Flu	☐ Yes ☐ No	Date:	_____
MMR	☐ Yes ☐ No	Date:	_____
Td/Tdap	☐ Yes ☐ No	Date:	_____
Chicken Pox (vaccine or illness)	☐ Yes ☐ No	Date:	_____

Occupational Hazards

Do you require a respirator, face mask, or nose/mouth guard? _____
Will you be lifting more than fifty pounds on a regular basis? _____
Will you be exposed to human fluids (blood, feces, etc.)? _____
Will you be exposed to poisonous or radioactive chemicals? _____
Will you be operating heavy machinery/driving a vehicle?

_____ _____
Signature Date