UNIVERSAL PHYSICAL EXAMINATION FORM

Name: _____ Employer: _____ DOS: _____

SSN: _____ Acct: _____ Job Title: _____

Birth date: _____ Age: _____ Pt. Phone #: _____

Page 1 PATIENT HISTORY

Breathing Problems:		**Spine Problems:**	
Asthma	_____ Yes _____ No	Back Injury/Back Pain	_____ Yes _____ No
COPD	_____ Yes _____ No	Neck Injury	_____ Yes _____ No
Sleep Apnea	_____ Yes _____ No	Pinched Nerve	_____ Yes _____ No
		Disc Herniation	_____ Yes _____ No
Skin Problems:		Disc Surgery	_____ Yes _____ No
Ulcers	_____ Yes _____ No	Fusion Surgery	_____ Yes _____ No
Eczema	_____ Yes _____ No	Laminectomy Surgery	_____ Yes _____ No
		Chiropractic Treatment	_____ Yes _____ No
Heart Problems:			
Abnormal Rhythm	_____ Yes _____ No	**General Orthopedic Problems:**	
Heart Attack	_____ Yes _____ No	Pain	_____ Yes _____ No
Heart Surgery	_____ Yes _____ No	Surgery	_____ Yes _____ No
High Blood Pressure	_____ Yes _____ No	Fracture	_____ Yes _____ No
Fainting/Lightheadedness	_____ Yes _____ No	Dislocation	_____ Yes _____ No
		Joint Problems	_____ Yes _____ No
Kidney/Liver Disease:		Joint Replacement	_____ Yes _____ No
Cirrhosis	_____ Yes _____ No	Arthritis	_____ Yes _____ No
Renal Failure	_____ Yes _____ No	Tendonitis	_____ Yes _____ No
Dialysis	_____ Yes _____ No	Carpal Tunnel	_____ Yes _____ No
		Rotator Cuff	_____ Yes _____ No
Neurological Problems:		Shoulder Problems	_____ Yes _____ No
Seizures	_____ Yes _____ No		
Stroke	_____ Yes _____ No	**Any difficulty or pain with any of the following:**	
Weakness	_____ Yes _____ No	Lifting 30 lbs?	_____ Yes _____ No
Numbness/Tingling	_____ Yes _____ No	Lifting 50 lbs?	_____ Yes _____ No
		Lifting 75 lbs?	_____ Yes _____ No
Tumors/Cancer	_____ Yes _____ No	Repetitive bending?	_____ Yes _____ No
Tuberculosis	_____ Yes _____ No	Reaching/Lifting overhead?	_____ Yes _____ No
Narcotic Medication	_____ Yes _____ No	Repetitive or strong grasping?	_____ Yes _____ No
Vision or Hearing Problems	_____ Yes _____ No		
Daytime Sleepiness	_____ Yes _____ No	Surgeries:	_____ Yes _____ No
Diabetes	_____ Yes _____ No		
Hernia	_____ Yes _____ No	Are you pregnant?	_____ Yes _____ No
Bleeding Problems	_____ Yes _____ No		

Toxic Substances Exposure:	
Asbestos	_____ Yes _____ No
Chromium VII	_____ Yes _____ No
Lead	_____ Yes _____ No
Mercury	_____ Yes _____ No
Respirable Silica	_____ Yes _____ No
Other	

Medications: _____	Allergies: _____

Page 2 PHYSICAL EXAMINATION

Initials	BP	P	R		Visual Acuity	Right	Left	Both
	Wt	Ht			Uncorrected	20/_____	20/_____	20/_____

Color Vision: _____ Normal _____ Abnormal Depth Perception: _____ Normal _____ Abnormal

	NORMAL	ABNORMAL	DESCRIBE ANY ABNORMAL FINDINGS
General Appearance/Gait			
HEENT/Nasal Septum			
C-V			
Lungs			
Abd/Hernia (males)			
Spine			
Extremities			
Neuro			
Tinel's/Phalen's			
Skin			

Provider: Please address in detail (dates needed) all YES answers in patient history and abnormal findings:
_____
_____
_____
_____

☐ Patient advised to follow up with PCP regarding a non-placement relevant medical condition: _____
_____

☐ Patient was advised additional medical documentation is necessary prior to a placement determination:

- ☐ Cardiology Records _____
- ☐ CPAP Compliance Report _____
- ☐ Neurology Records _____
- ☐ Orthopedic Records _____
- ☐ Other _____
_____

Page 3 PLACEMENT RECOMMENDATIONS

RECOMMENDATIONS FOR JOB PLACEMENT / FITNESS FOR DUTY

☐ May work full duty without accommodation

☐ May work with accommodation: _____

☐ Further testing or documentation is necessary prior to placement/fitness for duty: _____
_____

REGULATORY EXAMINATIONS

Having completed the applicable OSHA compliant medical surveillance protocol, I have determined that this applicant is safe and able to work and is granted the following clearance(s):

☐ Asbestos Clearance ☐ Firefighter Clearance (NFPA 1582) ☐ Police Clearance

☐ Chromium Clearance ☐ Forklift Clearance ☐ Respirator Clearance

☐ Crane Operator Clearance ☐ Lead Clearance ☐ Silica Clearance

☐ Other: _____

☐ Further testing or documentation is necessary prior to clearance: _____
_____
_____

PRE-SURGICAL EXAMS
MEDICALLY CLEARED FOR SURGERY: _____ Yes _____ No _____

HEALTHCARE WORKER CLEARANCE

☐ Free of communicable disease upon exam with no TB test performed

☐ Free of communicable disease upon exam and TB test performed

SIGNATURE: _____ **DATE**: _____

Above information reported to _____ (Date) _____ (Time) _____ By: _____