



**IV. Significant Medical Conditions (✓)**

	Yes	No	If Yes, Explain:
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac .....	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol .....	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus .....	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension .....	<input type="checkbox"/>	<input type="checkbox"/>	
Neuromuscular Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic Condition .....	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Illness .....	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify) .....	<input type="checkbox"/>	<input type="checkbox"/>	

**V. Report of Physical Examination (✓)**

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches) _____				
Weight (pounds) _____				
Pulse _____				
Blood Pressure _____				
Hair/Scalp				
Skin				
Eyes - Visual Acuity: R _____ L _____				
Eyes - Color Vision				
Ears - Hearing (dB) R _____ L _____				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart - Murmur, etc...				
Lungs - Adventitious Findings				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication or which might affect his/her work role? If so, specify \_\_\_\_\_

\_\_\_\_\_  
Physician Name (Print)

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date