Trinity Occupational Health
10200 Trinity Parkway, Suite 204
Stockton, CA 95219

PHYSICAL EXAMINATION

DATE _____

NAME _____ COMPANY: _____
LAST FIRST MI

ADDRESS_____ CITY_____ STATE ZIP_____ PHONE _____

BIRTH DATE ____/____/____ AGE_____ SOC. SEC # _____

Have you ever had or do you have any of the following? (Check "Yes" or "No")

	YES	NO
1. Severe headaches		
2. Head injury		
3. Hearing loss or ear trouble		
4. Hayfever		
5. Allergies		
6. Chronic cough		
7. Shortness of breath		
8. Asthma		
9. Heart trouble		
10. High blood pressure		
11. Rheumatic fever		
12. Stomach or duodenal ulcer		
13. Gallbladder trouble		
14. Rupture (hernia)		
15. Kidney trouble		
16. Dislocations of joints		
17. Broken bones		
18. Bone or joint problems		
19. Rheumatism or arthritis		
20. Back pain or injury		

	YES	NO
21. Knee injury		
22. Varicose veins		
23. Skin problems or chronic rash		
24. Nervous disorders		
25. Fainting spells		
26. Epilepsy		
27. Complications from childhood diseases		
28. Diabetes		
29. Tuberculosis		
30. Cancer		
31. Tumor		
32. Yellow jaundice (hepatitis)		
33. Anemia		
34. Alcohol excess (drinking problem)		
35. Date of last menstrual period		
36. Menstrual abnormalities		
37. Obstetrical or GYN disorders		

	YES	NO
38. Have you ever had a work-loss injury or illness?		
39. Have you ever received compensation for an industrial injury?		
40. Are you at present under a doctor's care for any condition?		
41. Are you taking any medication at this time?		
42. Have you ever, or do you now take habit-forming drugs or narcotics?		
43. Have you ever had any operations?		
If yes, list name and date of operation(s)_____		
44. Do you have chronic draining sores or infections?		
45. Military record with medical or dishonorable discharge?		
46. When was your last tetanus shot?_____		
47. Do you wear glasses?		
48. Do you wear contact lenses?		
49. Date of last chest x-ray _____ Results_____		
50. HAVE YOU HAD ANY ILLNESS OR INJURY SINCE YOUR LAST EXAMINATION?		

DETAILS OF ALL "YES" ANSWERS ABOVE: _____

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE, AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A REPORT TO MY EMPLOYER.

DATE:_____ SIGNATURE:_____

Name: _____ Date: _____

Last First MI

Height _____ Weight _____ Temperature _____ Pulse _____ Blood Pressure _____

Vision: Distant Uncorrected: R 20/____ L 20/____; Corrected: R 20/____ L 20/____, Glasses _____

Near Uncorrected: R 20/____ L 20/____; Corrected: R 20/____ L 20/____; Contacts _____

Hearing:
Y = Response
N = No Response

	500	1000	2000	4000	
					Right Ear
					Left Ear

Frequency (HZ)

Color Vision _____Normal
_____Deficient
_____Recognizes basic colors

Tested by _____

— Normal Range + Abnormal (Details) O= None N/E Not Examined	CODE	DETAILS OF ALL +
SKIN		
HEAD		
EYES		
EARS, NOSE & THROAT		
NECK		
CHEST & LUNGS		
BREASTS		
HEART		
ABDOMEN		
HERNIA		
GENITO URINARY		
RECTAL — Hemorrhoids		
RECTAL — Prostate		
UPPER EXTREMITIES		
BACK & SPINE		
LOWER EXTREMITIES		
VARICOSE VEINS		
ENDOCRINE		
OTHER		

LABORATORY (N = NORMAL)

All Others: _____

Urinalysis: Alb. _____ Sugar _____

Micro _____

SMA-12 _____

Liver Panel _____

EKG _____

Vitalor _____

Other _____

X-RAYS

Back _____

Chest _____

Other _____

CLASSIFICATION:

_____ A. No significant abnormalities, no medical work restrictions.

_____ B. Findings correctable and/or not serious. Medically will allow anticipated work.

_____ C. Medical findings requiring moderate work restrictions.

_____ D. Medical findings requiring major work restrictions.

IMPRESSION: _____ HEALTHY PERSON _____ OTHER: _____

_____ LAB WORK & X-RAY PENDING.

RECOMMENDATION: _____

_____

_____

_____

_____, M.D.