TRINITY
URGENT CARE

10200 Trinity Pkwy #202 Stockton, CA 95212
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Pre-Employment History and Physical Form

Personal Data

Name (Last,First, MI):		SSN:	
Date of Birth: / / Age:		Ethnicity:	
Phone Numbers:	Home ( ) -	Mobile ( ) -	Work ( ) -
Address: (street) (city)		(state) (zip)	
Job Title & Department:		Union: ☐ Yes ☐ No If yes, specify:	

Current Medical Provider

Name of Provider:	Phone Number: ( ) -
Address:	

Prior Employment Start with most recent job

	Job Title	Employer/City/State	Dates of Employment (mo/yr)
1			/ to /
2			/ to /
3			/ to /
4			/ to /

Review of Symptoms

Do you have any of the following?	Yes	No	Do you have any of the following?	Yes	No
Weight loss/Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision/wear glasses			Abdominal pain		
Dizziness/Vertigo			Diarrhea/constipation		
Difficulty hearing			Irregular menstrual cycle		
Seasonal allergies			Frequent urinary tract infections		
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			A history of broken bones		
Wheezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		

Vaccination History/Communicable Diseases

Have you had:	Yes	No	Unsure
The standard series of childhood vaccinations (to the best of your knowledge)?			
The disease “chicken pox” or the chicken pox vaccine (varicella)?			
A tetanus/diphtheria booster shot within the last 10 years?			
Hepatitis B vaccination (this is a series of three injections spaced several months apart)?			
The disease “Tuberculosos”?			
A positive tuberculosis test (also called a PPD or Tine test)?			

Have you ever had: ☐a car accident ☐loss of consciousness ☐heat attack ☐loss of vision ☐psychiatric disorder ☐abnormal heart rhythm ☐seizure ☐panic attacks ☐head injury ☐stroke ☐paralysis ☐back injury

Current Medical Conditions Those that you are currently experiencing and/or receiving treatment for (diabetes, migraine, etc)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1		/	4		/
2		/	5		/
3		/	6		/

Past Medical Conditions Those that you had in the past but have recovered from (such as childhood asthma, gestational diabetes)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1			3		
2			4		

Surgeries/Hospitalizations List type of surgery (such as gallbladder) or condition for which you were hospitalized (heart attck,etc)

	Please List	Date of onset (mo/yr)		Please List	Date of onset (mo/yr)
1			3		
2			4		

When was your last visit to the emergency room?_____

For what symptom/condition _____

Family History Please list any conditions that run in your biological family (even if relative is deceased)

	Please List	Circle affected relative		Please List	Circle affected relative
1		Father / Mother / Sister / Brother / Child / Grandparents	3		Father / Mother / Sister / Brother / Child / Grandparents
2		Father / Mother / Sister / Brother / Child / Grandparents	4		Father / Mother / Sister / Brother / Child / Grandparents

Medications Please include non-prescription medications, vitamins, and herbal supplements in addition to prescription medications

1		4		7	
2		5		8	
3		6		9	

Do you have any allergies to medications or substances? ☐ **Yes** ☐ **No** (If yes, specify)

_____

_____

Social History

Do you smoke cigarettes? (circle one) Yes / No / used to smoke, but quit	If Yes, how many cigarettes per day? _____ per week? _____
How many alcoholic drinks do you consume per day? _____ per week? _____	Do you use illicit/illegal drugs? (circle one) Yes / No
How many minutes of exercise do you get per day? _____	How many days a week do you exercise? _____
How many hours of television do you watch per day? _____	How many time do you eat fast food per week? _____

Physical Examination

Height	Weight	BMI	Blood Pressure	Pulse	Respirations	Temperature

Vision: Uncorrected / Corrected (circle) OD - ___/___ OS - ___/___ OU - ___/___

HEENT: _____

Neck: _____

Chest/Lungs: _____

Heart: _____

Abdomen: _____

Musculoskeletal: _____

Neurological: _____

Skin: _____

Other: _____

Assessment: _____

_____

_____

_____

_____

_____

Provider Signature: _____

Date: _____