MEMORIAL HEALTH SYSTEM

Name: _____

Date of Birth: _____

SS#: _____

Department/Title: _____

Date of Physical Exam: _____

Post Offer Physical Examination is: ☐ Complete ☐ Pending Medical Clearance

_____ _____

Signature of Physician/Nurse Practitioner completing physical exam Date of exam

Section to be completed and faxed to Human Resources once PPD, Drug Screen, and Physical Exam are completed

_____ Date Qualified

_____ Date Failed

_____ _____

Signature of Physician/Nurse Practitioner Date

Please fax completed form to Human Resources @ 568-5383

MEMORIAL HEALTH SYSTEMS PRE-PLACEMENT PHYSICAL EXAM

Name: _____ Date of Birth: _____ Date: _____

Department: _____ Job Title: _____ Facility: _____

Medical History	Yes	No	Unsure	Details
Have you received any compensation awards, disability insurance or pension because of illness or injury?				
Have you had any surgery or hospitalization? Dates? Reasons?				
Any eye or ear conditions?				
Have you ever been told you have a heart or blood vessel disease?				
Have you or any blood relative ever had a heart attack?				
Have you ever had an abnormal electrocardiogram (EKG)?				
Have you ever had angina, thumping or racing of your heart beat?				
Have you ever had any heart murmurs?				
Do you get any regular vigorous exercise?				
Have you ever been told you had high blood pressure?				
Do you ever have shortness of breath?				
Do you have any difficulty using respirators?				
Have you ever had asthma or any lung or chest disorder or surgery?				
Have you ever had a hernia? Location?				
Are you pregnant?				
Have you had bone or joint disease, factures or dislocations?				
Have you had back or neck injuries, pain or other disorders?				
Have you ever had a skin reaction to any substances or any persistent or recurrent skin conditions?				
Have you ever had a seizure, convulsion, repeated fainting or dizzy spells?				
Have you ever had migraines, recurrent headaches or head injury?				
Have you ever had neuralgia, neuritis, nerve disorders or injury?				
Have you ever had a psychiatric or emotional illness or nervous disorder?				
Have you ever had or do you have diabetes or excessive thirst?				
Have you ever had abdominal disorders such as stomach or intestinal spasms, ulcer, colitis, diverticulitis, pancreatitis or other disorder?				

History of Diseases: Immunization Records Provided □ Yes □ No

Have you ever had:	Yes	No	Unsure	Have you ever had:	Yes	No	Unsure
Measles				Scarlet Fever			
Typhoid Fever				Tuberculosis			
Dysentery				Mumps			
Whooping Cough				Chicken Pox			
Diphtheria							

Name: _____ Date of Birth: _____

Address: _____ City: _____ State,Zip:_____

Home Phone: _____ Cell Phone: _____ Gender: _____

Vitals:

BP R Arm ____/_____	**BP L Arm ____/_____**	**Pulse _____ Temp_____**	**Wt _____**	**Ht _____' _____"**

Allergies:

Medications:

Recent Medical Treatment:

Surgeries:

Major Trauma:

Medical Conditions/Diseases:

Social History:

Have you ever smoked cigarettes, cigars, pipe, chewed tobacco or rubbed snuff? □ Yes □ No

Do you currently smoke or chew tobacco or rub snuff? □ Yes □ No

If yes, how much per day? _____ Have been advised to quit? □ Yes □ No

Do you drink alcohol? □ Yes □ No

If yes, how often? _____

I give my permission to release any and all information both written and verbal, regarding my medical conditions or files to MHS or its designee. I certify that all my responses are true to the best of my knowledge. I understand that any falsification of information may result in disciplinary action, up to and including termination of my employment with MHS.

_____ _____ _____

Print Name Signature of Employee Date

Name: _____ Date of Birth: _____

Physical Exam:

General
□ Well Nourished
□ Obese
□ Pale
□ Pink
□ NAD

Lungs
□ Clear A/P
□ Wheezing
□ Rhonchi

Respiratory
□ Easy/Unlabored
□ Dyspenic
□ Labored with Exertion
□ Labored

Heart
□ Regular Rate & Rhythm
□ Murmur

Abdomen
□ Soft BS x4
□ Organmegly

Spine-Flexion
□ Normal
□ Abnormal

Musculoskeletal-Gait
□ Normal
□ Abnormal

Inguinal Hernia (Male)
□ Normal
□ Abnormal

Vision:

Far – Uncorrected	**Far – Corrected**	**Near – Uncorrected**	**Near – Corrected**
Both 20/_____	Both 20/_____	Both 20/_____	Both 20/_____
Right 20/_____	Right 20/_____	Right 20/_____	Right 20/_____
Left 20/_____	Left 20/_____	Left 20/_____	Left 20/_____

Color Vision
□ Basic
□ Normal
□ Abnormal

Binocular Vision
□ Yes
□ No

Corrected Used
□ Wears Glasses
□ Wears Contacts
□ Wears Reading Glasses

Horizontal Peripheral Vision
Right _____ (degrees – max 85)
Left _____ (degrees – max 85)

Back Requirements:

Lift Instructions Reviewed	□ Yes	□ No
Lift Performed	□ Yes	□ No
Back Pamphlet Given	□ Yes	□ No
Flex & Extension Exam	□ Yes	□ No

Comments:

_____ _____
Signature of Medical Examiner Date Exam Completed

Name: _____ Date of Birth: _____

New Employee TB Screening and Consent Form

Have you ever had TB or been exposed to TB?	□ Yes	□ No
Have you ever had a reaction to TB skin test?	□ Yes	□ No
Have you been treated for TB infection or disease?	□ Yes	□ No
Are you foreign-born?	□ Yes	□ No
Have you had BCG live vaccine?	□ Yes	□ No
Have you had a live vaccine in the past 4 weeks (i.e. MMR, Chickenpox, other)?	□ Yes	□ No
Are you taking medicines that affect immunity (i.e. steroids)?	□ Yes	□ No
Do you have a health condition that may interfere with TB testing?	□ Yes	□ No

If yes to any of the above, please explain: _____

Date of last TB test, if known: _____

□ I consent to administration of the tuberculosis skin test.

□ I do not consent to TB skin testing. Please explain: _____

If you are HIV Positive please notify the Employee Health Director before the administration of the TB skin test.

_____ _____

Employee Signature Date

For Office Use

Tubersol 5 TU (0.1 mL) intradermal						
Date Given	Arm	Lot #	Given By	Date Read	Result in mm	Read By
	R / L					

If your 1st PPD is read somewhere other than MOHP, please fax form to (740) 374-7230 immediately.

Tubersol 5 TU (0.1 mL) intradermal						
Date Given	Arm	Lot #	Given By	Date Read	Result in mm	Read By
	R / L					

If your 2nd PPD is read somewhere other than Employee Health, please fax form to:
MMH Employees – (740) 374-4977
Selby Employees – (740) 568–2029 Attn Anna Smith