Pre-Employment Physical Forms

Patient Name: _____ **Date:** _____

Gender: ☐ Female ☐ Male **Marital Status:** ☐ Single ☐ Married ☐ Divorce ☐ Widowed

Address:		
City:	**State:**	**Zip Code:**
Home Phone:	**Mobile:**	
Preferred Langue:		
Email Address:		

REVIEW OF SYSTEMS

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 lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea / Constipation		
Seasonal allergies			Irregular periods		
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			History of broken bones		
Sneezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		
Allergies High			High Blood Pressure		
Carpal Tunnel			Tunnel Syndrome Diabetes		
Loss of memory			Depression, Anxiety		

Do you have allergies to any medications or other substances? ☐ Yes ☐ No