

Name (Last, First)				Social Security Number		Today's Date	
Birthdate	Age	Sex	Race	Work Location			
Home Phone		Work Phone		Job Title or Assignment			
Home Address (Street, City, State and Zip Code)							

Examination Type (check appropriate box)

Pre-Placement
 DOT
 HAZWOPER
 Audiogram
 Respirator
 Other (list type) _____

Vital Signs

Weight (lbs) _____ Height _____ ft _____ in. Temperature _____ Pulse _____ Blood Pressure _____ BP Repeat _____

Pulmonary Functions

FVC observed _____ FVC% predicted _____ FEV1 observed _____ FEV1 % predicted _____ Observed FEV1/FVC _____

Vision				Color Test results				Tonometry		Urinalysis	
Uncorrected		Corrected		Not done		Fail blue/yellow		OD _____		Sp. Gr. _____ Blood _____	
OD	OS	OU	Far	OD	OS	OU	Far	OS _____		Protein _____ Sugar _____	
20/ _____	20/ _____	20/ _____		20/ _____	20/ _____	20/ _____		Depth Perception			
Horizontal visual field (degrees) Right _____ Left _____ Total _____											

Hearing		Fecal Occult Blood								PPD	
Protection	<input type="checkbox"/> Yes <input type="checkbox"/> No	500	1000	2000	3000	4000	6000	8000	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Not Done		Erythema _____ mm.
Protection type	<input type="checkbox"/> Plugs <input type="checkbox"/> Muffs	Right							<input type="checkbox"/> Pos. <input type="checkbox"/> Neg.		Induration _____ mm.
		Left									

* Chest X-Ray Not done Normal Suspicious Abnormal

* ECG Not done Normal Abnormal

* Cardiac Stress Test Not done Normal Borderline Abnormal

Examination (check one box for each category - explain abnormalities in comments)

		N	ABN	NE	Comments
1	Skin				
2	Eyes				
3	Ears				
4	Nose				
5	Mouth and throat				
6	Neck including thyroid				
7	Chest including breast				
8	Lungs				
9	Heart				
10	Abdomen				
11	Genitalia				
12	Anus and rectum				
13	Prostate				
14	Back and extremities				
15	Neurologic				
16	Other (explain)				

General state of health _____

Diagnosis _____

List any physical limitations or impairments _____

Examiner's Name (type or print)	Examiner's Signature	Date
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* Attach copy of reports. Do not send chest films.