



Physical Examination Form

ALL OPERATOR PROGRAMS

Please type or print neatly.

NAME: First _____		Middle _____		Last _____	
SOCIAL SECURITY # _____		DATE OF EXAMINATION _____			
MAILING ADDRESS _____				PHONE _____	
CITY _____				STATE _____ ZIP _____	

HEALTH HISTORY

Yes	No	Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease, or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN

GENERAL APPEARANCE AND DEVELOPMENT:

<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<input type="checkbox"/> Without corrective lenses	<input type="checkbox"/> With corrective lenses	

VISION: For distance ☐ Right/20 ☐ Left/20 ☐ Both/20

Evidence of disease or injury: Right _____ Left _____

Color test: Right _____ Left _____

Horizontal field of vision: Right _____ Left _____

HEARING: Right ear _____ Left ear _____

Evidence of disease or injury: Right ear _____ Left ear _____

AUDIOMETRIC TEST: ☐ 500 HZ ☐ 1000 HZ ☐ 2000 HZ ☐ 3000 HZ ☐ 4000 HZ

☐ 5000 HZ ☐ 6000 HZ ☐ 7000 HZ ☐ 8000 HZ

THROAT: _____

THORAX: Heart: _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after _____

Lungs: _____

ABDOMEN: Scars _____ Abdominal masses _____ Tenderness _____

Sample Of Physical Examination Form

Bradford P. Smith, Nicola Pusterla



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