



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

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

GENERAL APPEARANCE AND DEVELOPMENT:

VISION: For distance <input type="checkbox"/> Right/20 Evidence of disease or injury: Right _____ Left _____ Color test: Right _____ Left _____ Horizontal field of vision: Right _____ Left _____	<input type="checkbox"/> Good <input type="checkbox"/> Left/20 <input type="checkbox"/> Both/20	<input type="checkbox"/> Fair <input type="checkbox"/> Both/20 <input type="checkbox"/> Without corrective lenses <input type="checkbox"/> With corrective lenses
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HEARING: Right ear _____ Evidence of disease or injury: Right ear _____ Left ear _____	Left ear _____	Left ear _____
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AUDIOMETRIC TEST: <input type="checkbox"/> 500 HZ <input type="checkbox"/> 1000 HZ <input type="checkbox"/> 5000 HZ	<input type="checkbox"/> 2000 HZ <input type="checkbox"/> 6000 HZ	<input type="checkbox"/> 3000 HZ <input type="checkbox"/> 7000 HZ <input type="checkbox"/> 4000 HZ <input type="checkbox"/> 8000 HZ
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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

Center for Disease Control



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