



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	<input type="checkbox"/> Right/20	<input type="checkbox"/> Left/20	<input type="checkbox"/> 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:	<input type="checkbox"/> 500 HZ	<input type="checkbox"/> 1000 HZ	<input type="checkbox"/> 2000 HZ	<input type="checkbox"/> 3000 HZ	<input type="checkbox"/> 4000 HZ
		<input type="checkbox"/> 5000 HZ	<input type="checkbox"/> 6000 HZ	<input type="checkbox"/> 7000 HZ	<input type="checkbox"/> 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 _____

Physical Examination Form Example

Tom Brody



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Table of Contents Physical Examination Form Example

1. Understanding the eBook Physical Examination Form Example
 - The Rise of Digital Reading Physical Examination Form Example
 - Advantages of eBooks Over Traditional Books
2. Identifying Physical Examination Form Example
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Physical Examination Form Example
 - User-Friendly Interface
4. Exploring eBook Recommendations from Physical Examination Form Example
 - Personalized Recommendations
 - Physical Examination Form Example User Reviews and Ratings
 - Physical Examination Form Example and Bestseller Lists
5. Accessing Physical Examination Form Example Free and Paid eBooks
 - Physical Examination Form Example Public Domain eBooks

- Physical Examination Form Example eBook Subscription Services
- Physical Examination Form Example Budget-Friendly Options
- 6. Navigating Physical Examination Form Example eBook Formats
 - ePub, PDF, MOBI, and More
 - Physical Examination Form Example Compatibility with Devices
 - Physical Examination Form Example Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Physical Examination Form Example
 - Highlighting and Note-Taking Physical Examination Form Example
 - Interactive Elements Physical Examination Form Example
- 8. Staying Engaged with Physical Examination Form Example
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Physical Examination Form Example
- 9. Balancing eBooks and Physical Books Physical Examination Form Example
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Physical Examination Form Example
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Physical Examination Form Example
 - Setting Reading Goals Physical Examination Form Example
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Physical Examination Form Example
 - Fact-Checking eBook Content of Physical Examination Form Example
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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