Company: _____ Position: _____

PLEASE CHECK LIST BELOW AND COMPLETE							
DO YOU GET:	**Yes**	**No**	**Year**	**DO YOU GET:**	**Yes**	**No**	**Year**
Frequent headaches, dizzy or fainting spells				Stiff joints, trick shoulders or knees			
Convulsions, epilepsy or black-outs				Back problems (injury, strain, herniated disc, recurring ache)			
Vision loss, blindness, color blindness				Neck problems (injury, strain, herniated disc, recurring ache)			
Hepatitis				Rash from contact or allergy			

DO YOU CURRENTLY HAVE OR HAVE YOU HAD WITHIN THE LAST YEAR:					
	Yes	**No**		**Yes**	**No**
Head injury, skull fracture, whiplash			Hand, wrist or elbow problems		
Asthma or allergy to food or chemicals			Shoulder problems (rotator cuff, etc.)		
Ear trouble, decreased hearing			Bursitis, tendonitis		
Diabetes			Rheumatism, arthritis, gout		
Chronic bronchitis, cough, pneumonia			Hospitalizations for illness or injury		
Tuberculosis, spitting blood			Anemia or bleeding problems		
Chest pain, shortness of breath			Muscle disorder		
High blood pressure			Allergy to medication		
Stomach trouble, ulcers			Frequent nosebleeds		
Heart trouble			Frequent trouble swallowing		
Gallstones			Swelling of legs or ankles		
Kidney problems, frequent urination			Rheumatic fever		
Liver problems			Hernia or rupture		
Foot or ankle problems			Fractures of any degree		
Varicose veins, leg ulcers					

Explain all **Yes** answers: _____

GENERAL QUESTIONS

Do you have a condition that may require a special work assignment or accommodation if you are hired (walking, bending, lifting, standing)? _____

_____

Have you been advised to have a surgical operation or medical treatment that has not been done? _____

Are you presently under the care of a physician or chiropractor? _____

When was your last tetanus, diphtheria, pertussis booster? _____

Have you completed the series of three hepatitis B injections? _____ When? _____

List all medications you are currently taking: _____

_____

_____

_____

Do you smoke cigarettes? Yes No How many a day? _____ How many years? _____

Do you have any health concerns not mentioned above? _____

_____

_____

OCCUPATIONAL HISTORY

HAVE YOU EVER WORKED AT OR IN ANY OF THE FOLLOWING OCCUPATIONS?

	Yes	No		Yes	No
Mining			Asbestos		
Pottery			Quarry and Stone Cutting		
Sand Blasting			Welding		
Foundry			Car Body Repair or Lead Grinding		
Brick Manufacturing			Radiation Materials Exposure		
Glass Manufacturing					

I hereby certify that I have answered the questions above to the best of my knowledge and that the answers are true and complete. I authorize the Allina Hospitals & Clinics Occupational Health Program to release this information to my employer. I also authorize the Allina Hospitals & Clinics Occupational Health Program to release medical record information concerning me to my employer, including, but not limited to, the results of the history, physical examination, labs and other tests (including drug and alcohol testing) that Allina Hospitals & Clinics perform, and my health care provider's opinion regarding my ability to perform the job for which I am undergoing this examination.

Signature **X** _____ Date _____

To be completed by Clinic Staff:

HEIGHT	WEIGHT	PULSE	BLOOD PRESSURE (sitting)

URINALYSIS: (dip stick)
☐ Negative ☐ Positive

ABNORMAL FINDINGS:
☐ Glucose ☐ Protein ☐ Blood
☐ Other _____

RANDOM BLOOD SUGAR _____

VISION W/O GLASSES:
Distant (standard type only):
_____R _____L _____Both
Near vision values:
_____R _____L _____Both

VISION WITH GLASSES/CONTACTS:
Distant (standard type only):
_____R _____L _____Both
Near vision values:
_____R _____L _____Both

COLOR VISION:
☐ Ishihara
Results _____
☐ Primary
○ N ○ A

CHECK (✔) WHETHER: **Normal (N)** **Abnormal (A)** **Not Performed (O)**

	N	A	O	ABNORMAL FINDINGS
1. Development				
2. Skin				
3. Eyes				
4. Ears				
5. Nose & sinuses				
6. Throat				
7. Teeth & gums				
8. Thyroid gland & neck				
9. Lymph glands				
10. Chest				
11. Lungs				
12. Heart				
13. Abdomen				
14. Inguinal rings				
15. Spine				
16. Extremities				
17. Neurological, general				
18. Personality, general				

Summary of Findings _____

INJECTIONS or SKIN TEST:

☐ Medically recommended for position.
☐ Medical recommendation reserved pending additional medical information or treatment.
☐ Medically recommended with limitations as noted:

_____

THIS INDIVIDUAL: ☐ **has** ☐ **has not** been advised of the findings of this examination.

Physician Signature **X** _____ M.D. Date _____

NOTES / COMMENTS