# EMPLOYMENT PHYSICAL – PATIENT INFORMATION FORM

## APPLICANT INFORMATION

**Last Name: _____**
**First Name: _____**
**Date of birth: ____ / ____ / _____**
**Phone number: _____**
**Email: _____**
**Home address: _____**
**Employer requesting physical: _____**
**Employer Address: _____**
**Position applying for: _____**
**What type of physical is needed: (Check at least one)**
**☐ Pre-employment ☐Annual/recertification ☐ DOT ☐ CDL**

## JOB DUTIES

**(Helps provider understand physical requirements)**

**Please check all that apply to this job:**

☐ Heavy lifting (over 50 lbs) ☐ Moderate lifting (20–50 lbs) ☐ Prolonged standing ☐ Prolonged sitting ☐ Operating machinery ☐ Driving (commercial or non-commercial) ☐ Working at heights ☐ Exposure to chemicals ☐ Other:

## MEDICATIONS

**(List all current prescribed medications)**

_____
_____
_____

## ALLERGIES

☐ **No known allergies Allergies & reactions:**

_____
_____

## SOCIAL HISTORY

**Tobacco use:** ☐ Never ☐ Former ☐ Current

**Alcohol use:** ☐ None ☐ Occasional ☐ Regular Recreational drug use: ☐ No ☐ Yes

## CURRENT SYMPTOMS

**Are you experiencing any of the following today?** ☐ Chest pain ☐ Shortness of breath ☐ Dizziness ☐ Fainting ☐ Severe headache ☐ Injury ☐ Other:

_____

## WORK LIMITATIONS

**Have you ever been restricted from work due to medical conditions?** ☐ No ☐ Yes — If yes, explain: _____

## IMMUNIZATION HISTORY

(If known)

**Tdap:** ☐ Up to date ☐ Not sure Hepatitis B series: ☐ Completed ☐ Declined ☐ Not sure

**MMR:** ☐ Up to date ☐ Not sure Varicella: ☐ Up to date ☐ History of chickenpox COVID-19: ☐ Completed ☐ Not completed

## PATIENT ATTESTATION

I certify that the information provided is true and complete to the best of my knowledge.

**Signature:** _____ **Date:** ____ / ____ / _____

## FOR STAFF USE ONLY

**Vitals:** BP _____ / _____ HR _____ Temp _____ $SpO_2$ _____ Weight _____

**Vision:** Without correction: OD _____ OS _____ with correction: OD _____ OS _____

**Hearing:** ☐ Passed ☐ Needs further evaluation

**Urinalysis:** SG _____ Protein _____ Glucose _____

**Provider notes:**

_____

_____

**Provider name:** _____

**Signature:** _____ **Date:** ____ / ____ / _____


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