access omnicare
Inspiring health & wellness

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Phyiscals - Patient History
English

(Si usted preferiria una version en Espanol por favor pidasela a la recepcionista.)

_____, _____ _____ _____
Last Name First Name Social Security No. Date

Please list ALL PRESCRIPTION (and non-prescription) MEDICATIONS you are taking: ☐ **None**

(use bottom of page if needed - all medications unrelated to your injury or the safe performance of your job will remain strictly confidential)

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Please list all MEDICATION ALLERGIES (use bottom if needed)**:** ☐ **None Known**

1 _____ 2 _____ 3 _____

Please answer ALL QUESTIONS below:

	Do you have a history of …	NO	YES
1	**Ulcer or severe indigestion?**	☐	☐
2	Bone / joint injury / arthritis / bursitis?	☐	☐
3	Pain in neck, upper back or shoulders?	☐	☐
4	Pain in elbows, wrists or hands?	☐	☐
5	Tendinitis / carpal tunnel syndrome?	☐	☐
6	"I perform repetitive hand tasks"	☐	☐
7	Pain in hips, knees, ankles or feet?	☐	☐
8	Do your feet or ankles swell?	☐	☐
9	Hernia or swelling near groin?	☐	☐
10	Diabetes or high sugar levels in blood/urine?	☐	☐
11	Kidney or bladder disease?	☐	☐
12	Liver disease or hepatitis?	☐	☐
13	High blood pressure?	☐	☐
14	Heart disease?	☐	☐
15	Chest pain / pressure?	☐	☐
16	Major surgeries or recent hospitalizations?	☐	☐
17	Any prior work related injuries or illnesses?	☐	☐
18	Any permanent restrictions or limitations?	☐	☐
19	Do you exercise regularly?	☐	☐
20	Any loss of vision?	☐	☐

		NO	YES
21	Working in a hazardous environment with Chemicals, Asbestos, Lead, Noise etc…?	☐	☐
22	Do you smoke cigarettes? If yes, how much? _____ per day.	☐	☐
23	Do you drink alcohol? On average, how many per day? _____ beers or glasses wine / liquor	☐	☐
24	Any loss of hearing?	☐	☐
25	Any history of seizure, dizziness or passing out?	☐	☐
26	Any difficulty breathing, asthma or wheezing?	☐	☐
27	Ongoing skin disease or rash?	☐	☐
28	Any other medical / psychological conditions?	☐	☐
	Women only-		
29	**Are you pregnant?**	☐	☐
30	Any gynecologic disease ?	☐	☐
31	Date of last period / menstruation? _____		
	Neck / Upper Back / Shoulder / Arm / Hand Pain - Please answer:		
32	Are you mostly? ☐ Right Handed ☐ Left Handed		
33	"I use a computer about _____ hours per day." ☐ None		
34	"I mouse with: ☐ Right Hand ☐ Left Hand ☐ No mouse		

Please explain "YES" answers (use item number to identify problem):

_____

_____

_____

With my signature below, I am hereby authorizing Access Omni Care to provide me with any medical treatment & tests deemed necessary for my injury or physical exam and further give permission to release relevant medical information about my ability to work to my employer. I further give my permission to release previous medical records pertaining to this injury. To the best of my knowledge my responses to the above are complete and accurate. I understand that an intentional omission or misrepresentation of my medical history could lead to disciplinary action at a later date.

_____
Patient / Applicant Signature

History reviewed by: ☐ Manchester, M.D. ☐ _____ NP/PA

Completed by Patient:

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New Hire / FFD Exam

Last Name (Apellido) _____ , First Name (Nombre) _____ Date of Birth _____ Today's Date _____

Employer _____ Job Title _____ ☐ Light Work ☐ Heavy Work (>25 lbs)

Completed by Clinic:

Vital Signs:

BP_____ HR_____

HT_____ in. WT_____ lbs

Vision	Uncorrected			Corrected		
FAR:	**R** 20/	**L** 20/	**B** 20/	**R** 20/	**L** 20/	**B** 20/
NEAR:	**R** 20/	**L** 20/	**B** 20/	**R** 20/	**L** 20/	**B** 20/

Basic Color ☐ Red ☐ Yellow ☐ Green **Ishihara:** ___ /10

Onsite Urinalysis _____ Specific Gravity _____ glucose _____ ketones _____ protein _____ other **MA Initials:** _____

Body Part / System	WNL	
general appearance		
skin		
eyes		☐ No professional driving without visual correction
ears		☐ Recommend Audiogram: ☐ Attached ☐ Not Authorized
oropharynx		
neck		
chest / lungs		
heart		
abdomen		
groin / hernia		
hands / wrists / elbows		
shoulders / upper back		
lower back		
hips / knees		
ankles / feet		
neurological		

Based on the information available to me at the time of this examination the applicant/employee is:

☐ **Cleared for full duties** of the position above pending negative Urine Drug Screen if applicable.

☐ Cleared for unrestricted use of a **Respirator** ☐ Cleared for **Emergency Response Team**

☐ Cleared **except** : _____

_____

_____

Encouraged to exercise regularly and eat sensibly. Advised to continue routine medical and dental care.

Warned: ☐ stop or decrease use of tobacco products ☐ have breast / gyn. exam with personal MD

☐ gradual weight loss ☐ have rectal / prostrate exam with personal MD

☐ Follow up with personal MD for _____

_____ ☐ Manchester ☐ Chang NP ☐ Choi NP _____ _____

Clinician's Name Examiner Signature Date