Pre-Employment Physical Form

Personal Information

Name: _____ Date: _____

Address: _____

Phone: _____ Email: _____

DOB: _____ Sex: _____ Ethnicity: _____ Height: _____ Weight: _____

Primary Physician: _____ Phone: _____

Insurance Provider: _____ ID No. _____

Employment

Job Title: _____ Department: _____ EIN: _____

Previous Employer: _____ Dates: _____

Previous Employer: _____ Dates: _____

Current Symptoms (Check All That Apply)

☐ Headaches	☐ Joint Pain/Swelling	☐ Dizziness	☐ Numbness
☐ Nausea	☐ Vision Impairment	☐ Hearing Impairment	☐ Weight Loss/Gain
☐ Fevers	☐ Coughing/Wheezing	☐ Fatigue	☐ Chest/Back Pain

Medical History

Exercise Frequency: _____ Exercise Type(s): _____

Smoking Frequency: _____ Drinking Frequency: _____

Illicit Drug Frequency: _____ Fast Food Frequency: _____

Allergies: _____

Current Medications: _____

Current Diagnoses: _____

Current Injuries: _____

Previous Injuries: _____

Previous Medications: _____

Dates Treated: _____

Previous Medical Conditions: _____

Previous Surgeries: _____

Vaccinations

Standard Childhood Vaccinations	☐ Yes ☐ No	Date:	_____
Hepatitis A	☐ Yes ☐ No	Date:	_____
Hepatitis B	☐ Yes ☐ No	Date:	_____
Tuberculosis	☐ Yes ☐ No	Date:	_____
Flu	☐ Yes ☐ No	Date:	_____
MMR	☐ Yes ☐ No	Date:	_____
Td/Tdap	☐ Yes ☐ No	Date:	_____
Chicken Pox (vaccine or illness)	☐ Yes ☐ No	Date:	

_____ _____

Date **Signature of Applicant**

_____

Signature of Examining Physician