

MEDICAL EVALUATION

NAME: _____

AGE: _____

HEALTH HISTORY					
Allergies (foods, drugs & environment)	<input type="checkbox"/> No known allergies <input type="checkbox"/> Yes, _____				
Habits	<input type="checkbox"/> smoking, amount per day: _____ <input type="checkbox"/> alcohol drinking, amount per week: _____ <input type="checkbox"/> caffeine drinking, amount per day: _____ <input type="checkbox"/> street drugs, type & amount per day: _____				
Medicines currently taken	1. _____	2. _____	3. _____	4. _____	5. _____ 6. _____ 7. _____ 8. _____
List of all serious illnesses, operations, and hospitalizations	<input type="checkbox"/> None 1. _____ 2. _____ 3. _____ 4. _____				
Weight _____ Lb	Height _____ ft _____ in	BP _____	HR _____	RR _____	T _____
General appearance	<input type="checkbox"/> Alert, active, oriented, no distress, adequate weight <input type="checkbox"/> Other: _____				
REGION	NORMAL	ABNORMAL	DETAILS		
Head	<input type="checkbox"/>	<input type="checkbox"/>			
Ears	<input type="checkbox"/>	<input type="checkbox"/>			
Nose	<input type="checkbox"/>	<input type="checkbox"/>			
Throat	<input type="checkbox"/>	<input type="checkbox"/>			
Neck	<input type="checkbox"/>	<input type="checkbox"/>			
Chest	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Lungs	<input type="checkbox"/>	<input type="checkbox"/>			
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>			
Legs	<input type="checkbox"/>	<input type="checkbox"/>			
Skin	<input type="checkbox"/>	<input type="checkbox"/>			
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>			
Emotional/Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>			

After evaluating above described information, I hereby certify that _____
is able to work:

- WITHOUT ANY KIND OF RESTRICTIONS
 WITH RESTRICTIONS SPECIFIED AS FOLLOWS:

 See reverse for more details

EVALUATING PHYSICIAN'S SIGNATURE

DATE

LIC.

PRINT NAME

PHONE