

HEALTH CONDITION ASSESSMENT

An Equal Opportunity Employer

Confidential

(Please print all information)

1302 NE 3rd St
Bend, Oregon 97701
541-388-7799

All persons applying for employment are required to furnish health condition information and submit to an examination by a company designated physician. This information shall be used to determine appropriate job placement. It shall not be used to disqualify an otherwise qualified person who may have a mental or physical handicap. Read the instructions below carefully and provide all requested information accurately.

Form with fields: Last Name, First, Today's Date, Social Security Number, Position Applying For, Company Name, Name of Family Physician, Physician's Address/Phone

State whether or not you now have, or have ever had any of the following conditions by writing 'Yes' or 'No' in the space provided below, and qualify 'Yes' responses as appropriate by indication (F) Frequently (O) Occasionally (I) Infrequently. A response should be indicated for each condition.

Do not leave blanks.

Medical History

- 1. Alcoholism 2. Allergies 3. Appendix Removed 4. Asthma 5. Anemia or other Blood Diseases 6. Back or Spinal Injury 7. Back Trouble or Sore Back 8. Boils or Skin Disease 9. Bowel Habit Change 10. Breath Shortness 11. Broken Bones or Bone Disease 12. Cancer, Cyst, Growth or Tumor 13. Chest Pain 14. Color Blindness 15. Cough or Frequent Colds 16. Coughing or Vomiting Blood 17. Drug Abuse 18. Diabetes 19. Dislocated Vertebra 20. Ear or Throat Trouble 21. Elbow Injury or Trouble 22. Epilepsy 23. Eye Injury or Defect of Sight 24. Fainting Spells or Dizziness 25. Foot Trouble, Deformed Foot 26. Gall Bladder Trouble 27. Glasses or Contact Lenses 28. Gout 29. Hay Fever 30. Headache-Migraine, Frequent/ Severe 31. Head Injury-Any Type 32. Hearing Difficulties 33. Heart Trouble-Pain/Attack 34. High Blood Pressure 35. Kidney or Bladder Infection 36. Kidney Trouble, Blood in Urine, Stone 37. Knee Injury or Sprain 38. Liver Disease or Jaundice 39. Loss of Appetite 40. Neck Strain or Stiffness 41. Nervous Trouble or Breakdown 42. Nose or Sinus Trouble 43. Numbness, Weakness, Tiredness 44. Pneumonia or Pleurisy 45. Pounding Heart 46. Piles or Rectal Trouble 47. Polio or Meningitis 48. Prostate Trouble 49. Rash or Hives 50. Reaction from Medicine 51. Rheumatic Fever 52. Rheumatism or Arthritis 53. Rupture or Hernia 54. Shoulder, Arm, or Hand Pains 55. Stomach Trouble, Nausea/Vomiting 56. Stroke 57. Swelling of Ankles or Feet 58. Thyroid Trouble 59. Tonsils Removed 60. Trick or Locked Knee 61. Tuberculosis or Lung Trouble 62. Ulcers 63. Varicose Veins 64. Venereal Disease 65. Vision Difficulties 66. Weight Gain or Loss-Excessive

- 67. Have you ever had, or have now, illness or injuries other than those listed above?
68. Have you ever seen an orthopedist?
69. Have you ever had, or ever been advised to have, surgery?
70. Have you any physical complaint, impairment or disability at the present?
71. Are you taking any medicines or drugs now?
72. Are you able and willing to wear required safety protection such as safety shoes, hard hat, safety glasses, ear plugs, ear muffs, gloves, and other required safety gear?
73. Are you under the care of a doctor, healer or other practitioner at the present time?
74. Are there any drugs you cannot take because they make you sick?

- 75. When did you have your last tetanus Shot?
76. Are you Right Handed Left Handed
77. Do you Smoke? How Many Per Day? If Discontinued, How Long?
78. Do you use recreational drugs?

- 1. Have you ever had back pain which caused you to remain in bed? For how long? How often?
2. Have you ever seen a medical practitioner of any kind for a back problem? When? How long?
3. Have you ever been hospitalized for a back problem? What facility? How Long? Surgery?
4. Have you ever had X-Rays of your back? What Facility? Mylogram? CT Scan? Abnormal?
5. Have you ever been diagnosed to having a back problem such as arthritis or disc? What Facility? By Whom?
6. Have you ever injured your back in an automobile accident? Type of Injury?
7. Do you have back pain now? Have you had back pain recently? What part of back?
8. Have you ever seen a chiropractor? Now? How often do you receive treatment?
9. Do you lift weights? have you done so in the past? When?

- 1. Have you ever seen a medical practitioner of any kind for carpal tunnel syndrome and / or tendonitis? When? Physician?
2. Within the last 5 years have you experienced any of the following: Wake up in the night with tingling or numbness in the hand or fingers? numbness and tingling in the hand and fingers? Decreased sensation to hot and cold in the hand and fingers? Swelling of the thumb, wrist or fingers? Decreased ability to grasp objects between the fingers and thumb? Pain in the thumb, wrist or fingers?
3. Have you ever been diagnosed as having carpal tunnel syndrome or tendonitis?

If you have worked in the following occupations please indicate how long.

Asbestos Foundry Grinding Sand Blasting Spray or Brush Painting Chrome Plating Glass Mfg Mining
Silica Stone Cutting

- 1. Have you ever seen a medical practitioner of any kind for respiratory problems? When? Whome?
Have you ever been hospitalized for respiratory problem? When?
Have you ever had a chest X-Ray? When? Abnormal?
Have you ever had bronchitis? When? Treated By?

I affirm that the information provided herein is correct and complete and I understand that omissions or inaccuracies could be cause for termination of employment or rejection of my application for employment. I hereby consent to submit to a health examination as specified on the back of the form SIGNATURE

This Section Shall be completed by the Examining Physician, Not the applicant

PHYSICAL EXAMINATION

Please examine each of the following. Indicate normal (N) or abnormal (A) in the space and provide significant data in the section provided.

No.		N	A	No.		N	A	No.		N	A
1.	Temperature (C.)			9.	Head			21.	Cardiac Sounds		
2.	Pulse Rate (Per Min)			10.	Skin			22.	Blood Pressure		
3.	Height in./ cm)			11.	Ears			23.	Abdomen		
4.	Weight ()			12.	Nose			24.	Hernia		
5.	Eyes			13.	Mouth			25.	Genitalia		
6.	Vision	OU	Rt	Lt	14.	Teeth and Gums		26.	Upper Extremities		
	Distance				15.	Throat and Tonsils		27.	Lower Extremities		
	Near				16.	Thyroid and Neck		28.	Spine		
	Vision Corr:	OU	Rt	Lt	17.	Chest		29.	Rectal		
	Distance				18.	Vital Capacity (L. %)		30.	Peripheral Vascular System		
7.	Near				19.	Cardiac Size		31.	Lymphadenopathy		
8.	Color Vision				20.	Cardiac Rhythm		32.	Reflexes		

33. Back Examination
 X-Ray Results _____
 Surgical Scars _____
 Curvature _____
 Range of Motion
 Forward Flexion _____
 Lateral Flexion _____
 Extension _____

34. Urinalysis:

SpGr	pH	Glucose	Alb	Blood	Micro

Item No.	Significant Data from Physical Examination

Examining Physician's Comments

Medical History/Profile _____

 System Review _____

 Hospitalization and Surgery: _____

 Other: _____

DATE: _____ Physician's Signature _____
 Print Physician's Name _____