Midwest Occupational Medicine

Date:_____

PRE-PLACEMENT PHYSICAL EXAMINATION (To be filled out by applicant)

Name_____ Company_____

Address_____ Pre-Placement ☐ Annual ☐

City_____ Position/ Job Title:_____

State_____ Zip_____ Date of birth_____ Age_____ Sex: ☐ M ☐ F

Preferred Phone_____ Last four digits of Social Security Number_____

*** HAVE YOU ***EVER*** :	Yes	No	Year	*** HAVE YOU ***EVER HAD*** :	Yes	No	Year
1.Been operated on/had **surgery**: *list all surgeries in space provided on following pages*				33. Numbness tingling in the arms, legs, hands, feet, sciatica, or pinched nerves. **History of back or neck problems**			
2. Been advised to have an operation/surgery				34. History of bulging or ruptured disc in neck or back			
3. Been **Hospitalized**				35. Carpal Tunnel or other nerve problem, surgeries for this?			
4. Been seriously injured				36. Neuropathy, paralysis, CVA/stroke, TIA/transient ischemic attack, Multiple Sclerosis, Parkinson's, tremor, or other neuro			
5. Been refused employment for health reasons				37. Had **fractures**, childhood or adult			
6. Been forced to give up a job for health reasons				38. An **MRI** or **CT/CAT** scan on any body part			
7. Had a work-related injury or illness				39. Ever received Chiropractic or Physical Therapy treatment			
8. Received any pension for disability *(if military, list Service Connected percentage)*: *received permanent restrictions or limitations*				40. ***Check "Yes, No, Right, Left" for Items "a-k" below**, then list all information in space provide on following pages: diagnoses, year, treatments, MRI,CT, injections, surgeries, etc.*			
9. Been rejected from or discharged from the military service for health reasons				Problems with: a) Your back			
10. Been made ill by your work				b) Your neck			
11. Been refused a driver's license or DOT/CDL truck driver's card for health reasons				c) Your shoulders right or left			
12. Had eye problems, color blind, double vision				d) Your elbows right or left			
13. Had thyroid disorder or hormonal problems				e) Your arms or forearms right or left			
14. Had **diabetes,** hyper- or hypo-glycemia/sugar				f) Your wrists right or left			
15. Had a hernia or a rupture				g) Your hands or fingers right or left			
16. Had **high blood pressure**				h) Your legs or hips right or left			
17. Had difficulty hearing / ringing in ears/tinnitus				i) Your knees right or left			
18. Had ear drainage or a hole in your ear drum				j) Your ankle/feet/toes right or left			
19. Worked in a dusty trade				k) Other body parts			
20. Had psychiatric diagnosis, treatment, care, or counseling. Depression, anxiety, bipolar, schizophrenia, or other diagnosis. *explain in space provided on following pages*				41. **Cancer**: *list type, areas of body involved, treatment, in space provided on following pages*			
21. Had a frequent or chronic cough				42. Skin rashes, eczema, psoriasis, or other skin conditions			
22. Had asthma, emphysema or COPD: *list medication and treatment on next page*				43. Occupational skin disorder or rash			
23. Lung diseases: sarcoidosis, pulmonary fibrosis, occupational lung disease, or other				44. Vascular problems, swelling of legs or ankles, varicose veins, Raynaud's, aneurysm, or other			
24. Had shortness of breath not related to asthma, emphysema or COPD				45. Jaundice or hepatitis, fatty liver, cirrhosis, other liver problems			
25. Had heart attack/angina, heart failure, irregular heartbeat, valve or other heart trouble				46. GI problems: ulcers, Crohn's disease, Ulcerative Colitis, irritable bowel syndrome, diverticulitis, gastritis, or other			
26. Had pain/tightness in your chest with activities				47. Blood in urine, difficulty w urine, kidney, prostate problems			
27. Had to take medicine for your heart				48. Any infectious disease, **COVID-19**, TB, or other			
28. Had heart surgery, stent placement, bypass, ablation, or other procedures done to your heart				**49. ALLERGIES OR REACTIONS TO DRUGS** *please list*			
29. Been advised to get pacemaker/defibrillator				50. Decreased function in neck, back, or any joint or extremity			
30. Had fainting spells, dizziness, vertigo, passing out, or low blood pressure				51. Injuries from motor vehicle accidents – list year and treatment			
31. Had convulsions, seizures, or epilepsy, or other loss of consciousness				**52. IMPORTANT: Any other health problems not listed above** *please explain in space provided in following pages*			
32. Had frequent or chronic headaches				53. Are you in good health?			

***** (Important: This page must be filled out and signed.) *****

54. Is there any reason why you cannot wear safety shoes, respirator, or ear protection equipment?

_____

55. Any type of work that you cannot or do not wish to perform, or conditions in which you do not wish to be? (Please explain)

_____

56. **Female only**, date of last menstrual period: _____

57.**Smoking**: yes ☐ no ☐
Cigarettes ☐ other _____
Packs per day _____ How many years _____
Quit? ____ When? _____

58**. Alcohol**: yes ☐ no ☐ Type _____ Drink per week _____

59. Glasses or contacts? yes ☐ no ☐

60. Please list all medications currently prescribed to you *(please include supplements)* :

_____
_____
_____
_____
_____
_____

61. Continued explanations / lists for questions 1 through 53: *Please indicate the question number before each answer.*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

62. Type of work performed at your last three employers, plus years worked:
Last job_____
Job prior_____
Job prior to that_____
_____

63. Personal Physician: Name_____ Are you currently under the care of a healthcare provider? Yes☐ No☐

Certification by Employee: I certify that all my answers to the above questions of this confidential Pre-placement Physical Examination history form are truthful and complete.

Employee Signature: _____ **Date**:_____