COVENANT
OCCUPATIONAL HEALTH SERVICES
PHYSICAL EXAM

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Name:_____ Date of Birth:_____ Age:_____

Position Applied For:_____ Employer: _____

List all operations, hospitalizations, serious injuries or illnesses you have ever had:

Date	Nature	Physician	Resulting Disabilities

YOUR HEALTH HISTORY (check appropriate box)

- ☐ Anemia/Blood Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Tendencies
- ☐ Blood Clots
- ☐ Broken Bones/Dislocations
- ☐ Cancer or Tumor
- ☐ Color Vision Problems
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy/Convulsions
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental Health Problems
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other:_____

CURRENT MEDICATIONS

_____

_____

ALLERGIES

_____

_____

FAMILY HISTORY

Father	Mother
☐ Living	☐ Living
☐ Deceased (Age) ____	☐ Deceased (Age) ____
☐ Cancer	☐ Cancer
☐ Heart Disease	☐ Heart Disease
☐ High Blood Pressure	☐ High Blood Pressure
☐ Diabetes	☐ Diabetes
☐ _____	☐ _____

Other family members: _____

COVENANT HealthCare

SOCIAL HISTORY (please circle and specify)

Smoking History: ☐ Non-Smoker ☐ Smoker _____ packs per day for _____ years
☐ Ex-Smoker - stopped (month/year)_____ after smoking_____ packs per day for_____ years

Number of alcoholic beverages (beer, wine, cocktails, shots) per week _____
Number of caffeinated beverages (tea, coffee, cola) consumed per day _____

OCCUPATIONAL HISTORY

LIST MOST RECENT JOBS (LABORER, FARMER, SECRETARY, ETC.)	NUMBER OF YEARS WORKED	LIST POSSIBLE HAZARDS (CHEMICAL, DUSTS, ETC.)
1.		
2.		
3.		
4.		

Number of days lost from work over the past 12 months due to injury or illness:_____

Number of days lost from work in the last 5 years due to injury or illness: _____

Have you ever been refused employment or been unable to hold a job or stay in school because of a medical, physical or emotional reason? ☐ Yes ☐ No

Have you ever received or applied for compensation for any disability? ☐ Yes ☐ No

Do you have any condition that may require special accommodations at your new job? ☐ Yes ☐ No

If yes, to any of the above questions, please specify: _____

REVIEW OF SYSTEMS (check appropriate box)

☐ Abdominal Pain	☐ Dental Pain	☐ Incoordination	☐ Painful Urination
☐ Anxiety	☐ Depression	☐ Itching or Skin Rashes	☐ Passing Out
☐ Back Pain or Stiffness	☐ Difficulty Sleeping	☐ Loss of Vision	☐ Problems Breathing
☐ Black/Tarry Stool	☐ Dizziness	☐ Lumps or Nodules	☐ Problems Urinating
☐ Blood in Stool	☐ Fainting Spells	☐ Muscle Weakness	☐ Rapid Heart Beat
☐ Blood in Urine	☐ Food Intolerance	☐ Nasal Problems	☐ Slurred Speech
☐ Blurred Vision	☐ Frequent Sore Throat	☐ Nausea/Vomiting	☐ Swollen Ankles
☐ Change in Appetite	☐ Frequent Urination	☐ New Skin Moles	☐ Trouble Swallowing
☐ Chest Pain	☐ Headaches	☐ # of Pregnancies____	☐ Trouble With Balance
☐ Chronic Cough	☐ Hearing Loss	☐ Numbness/Tingling	☐ Vaginal Discharge
☐ Coughing Up Blood	☐ Heart Burn	☐ Painful Joints	☐ Varicose Veins

Other problems or concerns: _____

I hereby certify that the above answers are true and correct to the best of my knowledge. I understand that false answers may be cause for dismissal.

Patient Signature:_____ Date:_____