WILMINGTON HEALTH
Occupational Medicine

MEDICAL EXAMINATION

1202 Medical Center Drive, Wilmington, NC 28401
910.341.1542

Date _____ Name _____

HT _____ WT _____ BP _____ Pulse _____ Resp. _____

EYES

Far Vision

Uncorrected Both _____ R _____ L _____

Corrected Both _____ R _____ L _____

Color _____ Depth _____

Near Vision

Uncorrected Both_____ R _____ L _____

Corrected Both_____ R _____ L _____

EARS

Hearing R _____ L _____

Drums R _____ L _____

✓ **CHECK** if normal or negative. Copy and paste this checkmark or use a different symbol.

✖ **CROSS** if abnormal and give details below.

____ 1. General appearance	____ 10. Breasts	____ 19. Spine
____ 2. Skin	____ 11. Thorax	____ 20. Joints
____ 3. Scars	____ 12. Heart	____ 21. Extremities
____ 4. Nasal passages	____ 13. Pulses	____ 22. Varicosities
____ 5. Eyes	____ 14. Lungs	____ 23. Tremor
____ 6. Mouth, pharynx	____ 15. Abdomen	____ 24. Deep tendon reflex
____ 7. Teeth	____ 16. Hernia	____ 25. Other
____ 8. Thyroid	____ 17. Genitalia	
____ 9. Lymph nodes	____ 18. Rectum	

COMMENTS

_____

_____

_____

_____

_____

URINALYSES

SG _____ PH _____ Alb _____ Glu_____

TB SKIN TEST

○ Positive ○ Negative Reaction _____mm Time _____ ○ AM ○ PM

Physically Qualified for Employment ○ Yes ○ No

Physician's Signature _____

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MEDICAL HISTORY

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Patient Name _____ Date _____

Address/Apt./Suite _____

City _____ State _____ Zip Code _____

DOB ____/____/_____ SS# _____ Age ___ Sex ○ Male ○ Female Race _____

Allergies to Medications _____

Medications Currently Taking _____

HAVE YOU EVER HAD ✓ CHECK if YES then write what YEAR.

1. Cardiovascular
- ☐ _____ Heart trouble/angina
- ☐ _____ High blood pressure
- ☐ _____ Blood clots
- ☐ _____ Blood vessel problems

2. Respiratory
- ☐ _____ Asthma
- ☐ _____ Bronchitis
- ☐ _____ Pleurisy
- ☐ _____ Pneumonia
- ☐ _____ Sinus problems/allergies

3. Neurological
- ☐ _____ Seizures/epilepsy
- ☐ _____ Head injury
- ☐ _____ Stroke
- ☐ _____ Fainting/dizziness

4. Orthopaedic
- ☐ _____ Back problems
- ☐ _____ Broken bones
- ☐ _____ Arthritis, joint problems

5. Infectious Disease
- ☐ _____ Tuberculosis
- ☐ _____ Rheumatic fever
- ☐ _____ Meningitis
- ☐ _____ Recurrent tonsillitis
- ☐ _____ Venereal disease
- ☐ _____ Other

6. Psychiatric
- ☐ _____ Alcoholism
- ☐ _____ Drug dependency
- ☐ _____ Nervous trouble

7. Urologic
- ☐ _____ Urinary tract infections
- ☐ _____ Hernia

8. Miscellaneous
- ☐ _____ Ulcer problems
- ☐ _____ Diabetes
- ☐ _____ Skin disease
- ☐ _____ Other

- ☐ _____ **Serious injury**
- ☐ _____ **Surgeries (explain below)**
- ☐ _____ **Patient in hospital or clinic**

Have you recently had or do you have
- ☐ Frequent headaches
- ☐ Frequent colds or sore throat
- ☐ Earache or discharge from ear
- ☐ Hearing loss
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Shortness of breath
- ☐ Abnormal vision
- ☐ Frequent indigestion
- ☐ Hearing problems
- ☐ Menstrual problems
- ☐ Weight: normal or gain/loss

Explain

_____

_____

_____

_____

_____

I, the undersigned, do hereby certify that the answers to the above questions are true and give permission for the medical examination.

Signed _____

Remarks or additional history by examining physician _____

_____

_____