WILMINGTON HEALTH

MEDICAL EXAMINATION
1202 Medical Center Drive,
Wilmington NC, 28401
910-341-1542

Name _____ Date _____

HT:_____ WT:_____ BP: _____ Pulse:_____ Resp.: _____

Far Vision:

Uncorrected Both _____ R _____ L _____

Corrected Both _____ R _____ L _____

Near Vision:

Uncorrected Both _____ R _____ L _____

Corrected Both _____ R _____ L _____

Color: _____

Depth: _____

Ears: Hearing R_____ L _____

Drums R _____ L_____

Check if normal or negative; Cross (X) if abnormal and give details below.

1	Gen. 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	26	Other
9	Lymph Nodes	18	Rectum	27	Other

Urinalyses: SG: _____ PH:_____ Alb: _____ Glu: _____

T.B. Skin Test: Positive Negative _____ Reaction _____mm Time_____ AM/PM

Comments:

Physically Qualified for Employment ☐ YES ☐ NO

_____

Physician's Signature Date

MEDICAL HISTORY

Name_____ Date _____

DOB_____ Sex _____ Age_____ Race _____

Allergies to Medications: _____

Medications currently taking:_____

_____

HAVE YOU EVER HAD:	YES	YEAR
1. CARDIOVASCULAR		
Heart Trouble / Angina		
High Blood Pressure		
Blood Clots		
2. RESPIRATORY		
Asthma		
Bronchitis		
Pleurisy		
Pneumonia		
Sinus Problems/ Allergies		
3. NEUROLOGICAL		
Seizures / Epilepsy		
Head Injury		
Stroke		
Fainting / Dizziness		
4. ORTHOPEDIC		
Back Problems		
Broken Bones		
Arthritis, Joint Problems		
5. INFECTIOUS DISEASE		
Tuberculosis		
Rheumatic Fever		
Meningitis		
Recurrent Tonsillitis		
STD		
Other		
6. PSYCHIATRIC		
Alcoholism		
Drug Dependency		
Anxiety/Depression		
PTSD		

HAVE YOU EVER HAD:	YES	YEAR
7. UROLOGIC		
Urinary Tract Infections		
Hernia		
Prostate Problems		
8. MISCELLANEOUS		
Ulcer Problems		
Diabetes		
Skin Problems		
Serious Injury		
Surgical Operations (Explain)		
Hospitalizations		
9. GI SYSTEM		
Liver		
Gallblader		
Kidney		
10. HAVE YOU RECENTLY 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 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: _____

_____

_____