Work Physical Form

Date of Exam: _____ dd / mm / yyyy

EMPLOYEE / APPLICANT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender:

◯ Male ◯ Female ◯ Other

Address: _____ Email: _____

Contact Number: _____ Job Title / Position: _____

Department: _____

MEDICAL HISTORY

Known Allergies:

Current Medications:

Chronic Conditions or Ongoing Treatment:

Previous Surgeries / Hospitalizations:

PHYSICAL EXAMINATION

Height: _____ Weight: _____

Blood Pressure: _____ Heart Rate: _____

Vision Test:

Hearing Test:

Musculoskeletal Assessment:

◯ Normal ◯ Abnormal

Musculoskeletal Assessment – If abnormal, please provide more details:

ADDITIONAL TESTS

Drug Screening:

◯ Negative ◯ Positive

Drug Screening – If positive, please provide more details:

TB Test:

◯ Negative ◯ Positive

Other Tests:

FIT FOR WORK

Fit for Work:

◯ The employee/applicant is fit for work with no restrictions. ◯ The employee/applicant is fit for work with restrictions.

If employee/applicant is fit for work with restrictions, please specify restrictions:

PHYSICIAN'S INFORMATION

Name: _____ **License Number:** _____

Phone / Email: _____

Physician's Signature:

Employee / Applicant's Signature: