Confidential

History and Physical Examination Record

WorkersCare

A Division of

Canton Orthopaedics & Sports Medicine

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Douglas W. Clanton, MD

Company Name ______________________________ Employee Name ______________________________

Section One: **Past History and Review of Systems**

Do you have, or have you ever had (or been treated for) any of the following? If "yes", give details in remarks section below.

	Yes	No
1. Surgical Operation	☐	☐
2. Accident or Injury	☐	☐
3. Hospitalization	☐	☐
4. Syphilis	☐	☐
5. Gonorrhea	☐	☐
6. Tuberculosis	☐	☐
7. Cancer	☐	☐
8. Malaria or any other tropical disease	☐	☐
9. Rheumatic Fever	☐	☐
10. Rheumatism	☐	☐
11. Liver Disease	☐	☐
12. Gout	☐	☐
13. Hepatitis	☐	☐
14. Diabetes	☐	☐
15. Anemia	☐	☐
16. Leukemia	☐	☐
17. Any Blood Disease	☐	☐
18. Bleeding (anywhere)	☐	☐
19. Blood Transfusion	☐	☐
20. Asthma	☐	☐
21. Cough	☐	☐
22. Pleurisy	☐	☐
23. Disease of the Lung	☐	☐
24. Spitting or Coughing up blood	☐	☐
25. Chest Pains	☐	☐
26. Shortness of breath (day or night)	☐	☐
27. Pains around Heart	☐	☐
28. Heart Trouble	☐	☐
29. High Blood Pressure	☐	☐
30. Fast Heart Rate or Irregular beats	☐	☐
31. Swellling of feet or ankles	☐	☐
32. Disease of Blood Vessels	☐	☐
33. Hardening of Arteries	☐	☐
34. Varicose Veins or Phlebitis	☐	☐
35. Disease of the eyes	☐	☐
36. Blurred vision or blindness	☐	☐
37. Double Vision	☐	☐
38. Impaired hearing or ringing in ears	☐	☐
39. Kidney Disease or Kidney Stones	☐	☐
40. Urinary Bladder Disease	☐	☐
41. Passing Blood, Stones, or Gravel in urine	☐	☐
42. Any abnormality in Urine	☐	☐
43. Disease of Testicles	☐	☐
44. Organ	☐	☐
45. Rectal Abscess or other rectal conditions	☐	☐
46. Hemorrhoids (Piles)	☐	☐
47. Tumor or Growth	☐	☐
48. Goiter or Thyroid Disease	☐	☐
49. Any Nervous Disorder	☐	☐
50. Nervousness	☐	☐
51. Dizziness	☐	☐
52. Weakness	☐	☐
53. Fainting Spells	☐	☐
54. Numbness or Tingling in any part of your body	☐	☐
55. Nervous Breakdown	☐	☐
56. Alcoholism	☐	☐
57. "Blackout" or Unconsciousness	☐	☐
58. Quick Tempered	☐	☐
59. Cry Easily or Depressed Feeling	☐	☐
60. Any Mental Disorders	☐	☐
61. Epilepsy, Fits, or Convulsions	☐	☐
62. Headaches	☐	☐
63. Disease of Muscle or Bone	☐	☐
64. Loss of Strength, Tired, or Weak Feeling	☐	☐
65. Muscle Pains	☐	☐
66. Disease, Swelling, or Pain of Joints	☐	☐
67. Arthritis	☐	☐
68. Back Trouble	☐	☐
69. Locked or "Trick Knees"	☐	☐
70. Fracture, Break, Sprains	☐	☐
71. Disease of Stomach, Peptic or Duodenal	☐	☐
72. Nervous Stomach	☐	☐
73. Gained or Lost Weight recently	☐	☐
74. Recent change in Bowel Movement	☐	☐
75. Blood in Bowel Movement	☐	☐
76. Black Bowel Movement	☐	☐
77. Colitis or Dysentery	☐	☐
78. Jaundice	☐	☐
79. Skin Disease	☐	☐
80. Allergies or Hay Fever	☐	☐
81. Any other illness suffered within the past 5 years	☐	☐
82. Have you ever used marijuana, LSD, or habit-forming drug?	☐	☐
83. Do you have any disease, abnormality, or deformity, except as stated?	☐	☐

84. How much beer or liquor do you drink each day? ______________________________ .

85. Do you smoke? ________ cigarettes ______ cigars ______ pipe ______ If yes, how much? ____________

86. Are you on any diet? ______ If yes, what? ______________________________

REMARKS: Record question number and details of each "yes" response above.

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I hereby certify to the best of my knowledge that I have answered the above questions accurately. I understand that this medical history will be retained in my company file. I recognize that giving false information is in violation of the General Conduct Rules and could result in discipline up to and including discharge.

______________________________ DATE

______________________________ SIGNATURE

Section Two: **Family History**

Have your parents, brothers, sisters, or children ever been afflicted with any of the following?

	Yes	No		Yes	No
1. Cancer	☐	☐	6. Stroke	☐	☐
2. Tuberculosis	☐	☐	7. Epilepsy	☐	☐
3. Diabetes	☐	☐	8. Nervous Breakdown	☐	☐
4. Heart Trouble	☐	☐	9. Asthma, Hives, Hayfever	☐	☐
5. High Blood Pressure	☐	☐	10. Blood Disease	☐	☐

Section Three: **Physical Examination**

Temp	Pulse	B/P	Resp	Height	Weight	Last Tetanus

Visual Acuity ________ O.D. ________ O.S. ________ O.U. (uncorrected)

________ O.D. ________ O.S. ________ O.U. (corrected)

Color Vision ________ Yes ________ No

Describe each abnormality in space provided at right:

Normal	Abnormal		Normal	Abnormal	
1		General Appearance	13.		Lungs
2.		Head	14.		Heart
3.		Eyes	15.		Abdomen
4.		Eye Grounds	16.		Back - Pelvis - Spine
5.		Ears	17.		Upper Extremities
6.		Nose	18.		Lower Extremities
7.		Throat	19.		Neurological
8.		Teeth			
9.		Neck			
10.		Thyroid			
11.		Thorax			

Section Four: **Summary of Findings and Recommendations**

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Suitable for employment: ________ Not suitable for employment ________

Physician's Name (Print): DOUGLAS W. CLANTON, M.D. Date: ________

Physician's Signature: ________________________