Hammond-Henry CLINIC

Physical Examination

Name: _____ Date: _____/_____/_____
(last) (first)

Address: _____

Birthdate: _____/_____/_____ SS#: _____

Job for which applying: _____ Company: _____

Height: _____ Weight: _____ Pulse: _____ B/P: _____

Vision: without glasses: Right 20/ _____ with glasses: Right 20/_____
Left 20/ _____ Left 20/ _____

Color vision: _____ Depth perception: _____ Peripheral vision: _____

Hearing: Right: _____ Left: _____

Audiometric

Frequency	500	1000	2000	4000
Right:				
Left:				

	Normal	Abnormal	Remarks: Explain in detail
1. Head, neck, face, scalp			
2. Ears			
3. Nose			
4. Eyes			
5. Mouth, teeth, dentures, gums			
6. Pharynx, tonsils			
7. Chest, breasts, lungs			
8. Heart			
9. Abdomen			
10. Hernia: (location)			
11. Genitalia			
12. Anus, rectal			
13. Upper extremities			
14. Hands: Function			
15. Lower extremities			
16. Feet			
17. Spine			
18. Skin			
19. Neurologic			
20. Psychiatric			
21. Scar, identifying marks			

Special tests results: Urine: _____ Glucose: _____ Albumin: _____ Specific Gravity: _____

Blood: _____ X-Ray results: _____

EKG: _____

Pulmonary Function: FVC: _____ FEV: _____ FEV1/FVC: _____ % _____

Classification for work (indicate)

I Unrestricted – able to perform all types of work.

II Restricted – Able to work with restriction; specify. (Qualified handicapped) Examples: Respiratory disease, back condition, vision

III Deferred – Not acceptable for any type of work at this time. (Does not include those who can work with restrictions)

Reason for classification: include specific restrictions: _____

_____ _____
Provider Signature Date

PHYSICAL

F-127 C (12/17)
Reviewed (9/18)
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