St. Luke's WORKPLACE HEALTH

Occupational Health Examination

Name:
Patient ID:
Date of Birth: Age: Sex: ☐M ☐F
Phone: Cell:
Date of Visit:
Employer Name:

Have you ever had any of the following history, illness or complaints?

Check Each Item and provide approximate Date If Answer is Yes

	Yes	No	Date		Yes	No	Date
Abdominal Complaints	☐	☐		Headaches – Severe or Frequent	☐	☐	
Arthritis	☐	☐		Heart Disease	☐	☐	
Asthma	☐	☐		Hepatitis	☐	☐	
Back Pain or Injury	☐	☐		High Blood Pressure	☐	☐	
Blood or Pus In Urine	☐	☐		HIV	☐	☐	
Broken Bones	☐	☐		Kidney Disease	☐	☐	
Bronchitis	☐	☐		Latex Sensitivity	☐	☐	
Burning on Urination	☐	☐		Liver Disease/Jaundice	☐	☐	
Cancer or Tumor	☐	☐		Loss of Appetite	☐	☐	
Colds or Sore Throat Often	☐	☐		Nervousness	☐	☐	
Crohn's Disease	☐	☐		Pneumonia	☐	☐	
Diabetes	☐	☐		Rheumatic Fever	☐	☐	
Diarrhea	☐	☐		Sinus Issues	☐	☐	
Dizziness	☐	☐		Skin Rashes, Eczema, etc	☐	☐	
Drug and/or Alcohol Abuse	☐	☐		Sleep Problems	☐	☐	
Ear Troubles/Hearing	☐	☐		Smoking – Tobacco Use	☐	☐	
Epilepsy/Seizures	☐	☐		Stroke	☐	☐	
Eye Disease	☐	☐		Tingling in Hands or Feet	☐	☐	
Gallstones	☐	☐		Tuberculosis	☐	☐	
Goiter	☐	☐		Restrictions/Accommodations?	☐	☐	
Hospitalization	☐	☐					

Please explain any "Yes" answers:

Other Health Conditions, History or Illnesses not described above? ☐Yes ☐No **If Yes, explain below:**

Have you ever had any injuries: ☐Yes ☐No **If yes, please provide information on your injuries below:**

Did Any Injuries Cause You To Be Off Work or Restrict Work Activities? ☐Yes ☐No **If Yes, explain below:**

Surgeries? ☐Yes ☐No **If yes, please provide information on your surgeries below:**

Medications, OTC or Herbals:

Allergies:

I acknowledge by my signature below that all of the above information is true and complete.

Patient Signature **Date:**

Provider Comments on Medical History:

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Clinician:	Height	Weight	BMI
Blood Pressure: Systolic Diastolic		Pulse	Resp Temp

Vision-Uncorrected	Right Eye	Left Eye	Both	Vision-Corrected	Right Eye	Left Eye	Both
	20/	20/	20/		20/	20/	20/
Horizontal	degrees	degrees		Monocular Vision	☐Yes ☐No		
Urinalysis	Sp.Gr.	Protein		Blood		Sugar	

Provider (Check the Body Systems for Abnormalities):	Normal	Abnormal	Comment on All Abnormalities
General Appearance	☐	☐	
Skin	☐	☐	
Eyes/Pupils	☐	☐	
Ears	☐	☐	
Nose	☐	☐	
Mouth/Throat/Teeth	☐	☐	
Adenopathy	☐	☐	
Thyroid	☐	☐	
Lungs/Chest	☐	☐	
Cardiovascular	☐	☐	
Abdomen	☐	☐	
Back/Spine	☐	☐	
Extremities/Joints	☐	☐	
Neurological System Inc Joints	☐	☐	
Vascular	☐	☐	
Gait	☐	☐	
Genito-Urinary System	☐	☐	
Inguinal Hernia Present?	☐Yes	☐No	Comment:

Any Comments/Restrictions/Limitations?:

☐Accepted – No Restrictions
☐Accepted – Restrictions Noted Above
☐Subject to Reexamination – See Notes Above
☐Does not meet Requirements until patient provides requested information
- ☐Note from Primary Physician/Treating Physician
- ☐Patient Notified
- ☐Other:

Provider Signature:_____
Provider Name:_____ **Date:**_____ **Time:**_____