MIDWESTERN UNIVERSITY OPTI - AZCOM

PRE-EMPLOYMENT HISTORY AND PHYSICAL

Name _____ Birth Date _____Age _____

Department _____ Position _____

MEDICAL HISTORY

Childhood Illnesses & Immunizations

Please check the following childhood diseases & immunizations you have had.
Note: An official copy of your immunizations should be included with this form when returning it to Midwestern University.

	Yes	No		Yes	No
a. Measles	_____	_____	e. Diphtheria/Tetnus Toxoid	_____	_____
b. Mumps	_____	_____	f. Polio Oral	_____	_____
c. Chickenpox	_____	_____	g. Rubella	_____	_____
d. Scarlet Fever	_____	_____	h. Hepatitis	_____	_____

Hospitalizations

Have you been hospitalized for any reason (i.e. medical trauma, injury, mental illness, chemical dependency, operation, pregnancy)?

Hospital			
Year			
Reason			

Past Medical History

Please place an (X) next to any of the following conditions that you have or had in the past.

___	Cancer	____	Anemia
____	Allergies or Asthma	____	Heart Disease
____	Diabetes	____	Bleeding Tendencies
____	Tuberculosis	____	Stroke
____	Nervous Disorder	____	High Blood Pressure
____	Epilepsy	____	Needle Sticks
____	Back injuries	____	Recent Immigration
____	Recent travel outside USA	____	Other

Family Medical History

Please check the items that are pertinent to your family (children, brother, sister, parents, grandparents) medical history.

Family	Living Age	Deceased Cause	Deceased Age
Mother			
Father			
Sister (s)			
Brothers (s)			
Children			

Please place an (X) next to any of the following conditions that anyone in your immediate family has ever had.

____	Anemia	____	High Blood Pressure	____	Cancer
____	Allergies or Asthma	____	Heart Disease	____	Stroke
____	Diabetes	____	Bleeding Tendencies	____	Epilepsy
____	Tuberculosis	____	Nervous Disorder	____	Other

Illnesses & Medical Problems

Mark the problems you have or have had during the past year.

Ear & Eyes	Yes	No	Do Not Write Here
1. Visual problems	___	___	_____
2. Eye pain	___	___	_____
3. Eye infection	___	___	_____
4. Hearing problem	___	___	_____
5. Ear infection	___	___	_____
Respiratory System			
1. Nose bleeds	___	___	_____
2. Constantly running nose	___	___	_____
3. Wheezing	___	___	_____
4. Coughing	___	___	_____
5. Coughing up blood	___	___	_____
6. Severe sweats at night	___	___	_____
Genitqurinary			
1. Hernia/rupture	___	___	_____
2. Blood while urinating	___	___	_____
3. Pain while urinating	___	___	_____
4. Kidney stones	___	___	_____
5. Bladder infection	___	___	_____
6. Painful menstrual periods	___	___	_____
7. Vaginal discharge	___	___	_____
8. Irregular or heavy bleeding	___	___	_____

	Yes	No	Do Not Write Here
9. Yearly P.A.P./pelvic exams	___	___	_____

10. Last menstrual period ___ ___ _____

Date _____

Cardiovascular

1. Chest pain	___	___	_____
2. Shortness of breath	___	___	_____
3. Palpitations	___	___	_____
4. Ankle swelling	___	___	_____

Gastrointestinal

1. Heartburn	___	___	_____
2. Indigestion	___	___	_____
3. Poor appetite	___	___	_____
4. Bloody stools	___	___	_____
5. Constipation	___	___	_____
6. Ulcers	___	___	_____

Musculoskeletal

1. Joint pain	___	___	_____
2. Broken bones	___	___	_____
3. Joint swelling	___	___	_____
4. Chronic backache	___	___	_____

Mark the appropriate answers:

	Yes	No		Yes	No
1. Frequent severe headaches	___	___	Nervous condition	___	___
2. Dizzy spells	___	___	Weight changes	___	___
3. Numbness or tingling	___	___	Do you smoke?	___	___
4. Convultion/"fits"	___	___	Do you drink alcohol	___	___
5. Rashes	___	___	Do you exercise	___	___

Do you have any other health problems: Yes ____ No ____

If yes, please explain _____

_____

General Health: Excellent ____Good ____ Poor ____

Allergies: Do you have any allergies to medicine? Yes ____ No ____

If yes, please list_____

_____

Medications: Do you take any medications or drugs regularly? Yes ____ No ____

If yes, please list _____

_____

I hereby state that the information given herein is accurate and true to the best of my knowledge and that the Medical Center employees, including Medical Center Health Services, will not be held responsible for the result of misrepresented or withheld facts. I also state that I am physically capable of performing the responsibilities related to my employment and should I be unable to do so, I understand that such limitations may affect my employment status. I hereby give my consent to a physical examination and such tests consistent with the job description and the physical requirements necessary for the position for which I am seeking employment.

Date _____ Signature of Applicant _____

PLEASE DO NOT WRITE IN THE SECTION BELOW

Blood Pressure: RA _____ Weight _____ Height _____

LA _____ Vision: OD 20/

Temperature: _____ Oral Vision: OS 20/

Pulse: Rate _____ Rhythm _____ Color Vision _____

Respiration: Rate _____ Rhythm _____ Rhythm _____

General Appearance: _____

_____

_____

Eyes	**Normal**	**Abnormal**	**Heart/Vessels**	**Normal**	**Abnormal**
Lid	_____	_____	Rate	_____	_____
Sclera	_____	_____	Rhythm	_____	_____
Pupils	_____	_____	Pulses	_____	_____
Fundl	_____	_____			
Ears			**Abdomen**		
Hearing	_____	_____	Tenderness	_____	_____
Canal	_____	_____	Organs	_____	_____
Drum	_____	_____	Masses	_____	_____
			Hernia	_____	_____

Nose

	Normal	Abnormal
Septum	_____	_____
Mucosa	_____	_____

Mouth/Throat

Tonsils	_____	_____
Tongue	_____	_____
Gums	_____	_____
Teeth	_____	_____

Chest/Lungs

Sounds	_____	_____
Expansion	_____	_____
Breast	_____	_____

Rectum

	Normal	Abnormal
Hemorrhoid	_____	_____
Masses	_____	_____
Sphincter	_____	_____

GU Male

Penis	_____	_____
Testicles	_____	_____
Prostate	_____	_____

Gyne

Labia	_____	_____
Adnexa	_____	_____
Cervix	_____	_____
Vagina	_____	_____

Extremities & Back

Back	Normal _____	Abnormal _____
Extremities	Normal _____	Abnormal _____
Muscle Strength	Normal _____	Abnormal _____
Arms	Normal _____	Abnormal _____

Assessment _____ Lab _____

_____ _____

Plan _____ PPD _____

_____ CXR _____

_____ _____

Recommend Employment Yes ____ No ____

_____ _____
Physician Signature Date

_____ _____
Nurse Signature Date