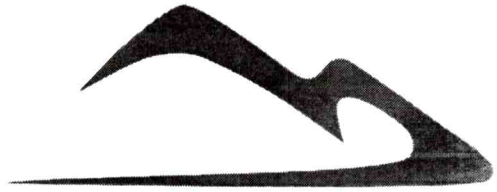

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PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY**_____ **ZIP CODE**_____

DOB_____ **PHONE**_____

EMPLOYER NAME_____

MEDICAL SURVEILLANCE

19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPINION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

TESTING

BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS

TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY

CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
MMR TITER
GLUCOMETER FINGER STICK
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW/2 VIEW
URINALYSIS
PSA
OTHER _____

WORKERS COMPENSATION

NEW PATIENT

99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT

99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

DIAGNOSIS

INTERNAL NOTES:_____

_____

_____

_____

_____

_____

_____

SIGNATURE – MEDICAL PROVIDER

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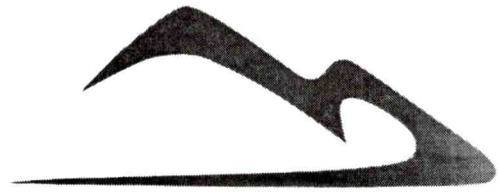

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Your Health And Safety Source

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Med, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVIDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Med's HIPAA policy regarding the use of disclosure of protected health information, which is made in accordance with Federal Law (electronic version is available at www.easternmed.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

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Medical History

Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Phone: _____

Have you ever had, or do you now have, any of the following? Check Yes or No, indicate age:

	Yes	No	Age
Surgery/Severe Injury			
Cancer/Tumor/Cyst			
Anemia/ Blood Disease			
Diabetes			
High Blood Pressure			
Thyroid Issues			
Skin Issues			
Ear/Nose/Throat Issues			
Eye Issues			
Lung Issues			
Heart Conditions			
Chicken Pox			
MMR			
Rheumatic/Scarlet Fever			
Phlebitis/ Blood Clot			

	Yes	No	Age
Abdominal/Ulcer Issues			
Kidney Disease/Stones			
Bladder/Prostate Issues			
Hernia (Rupture)			
Hemmorrhoids			
Varicose Veins			
Hand/Wrist/Arm Issues			
Foot/Ankle/Leg Issues			
Head/Neck/Spine Issues			
Back/Spine Pain			
Neurological Conditions			
Emotional Conditions			
Neuritis/Pinched Nerves			
Broken Bones			
Other			

If Yes, please explain: _____

_____

_____

_____

_____

Date of last tetanus shot: _____ Date of last Tuberculosis (TB) test: _____

Do you take mediciations? ____Yes ____No If Yes, please list them: _____

_____

_____

Are you allergic to any medications? ___Yes ___No If yes, to what? _____

Allergies other than medications: _____

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Do you currently smoke? ___Yes ___No If yes, # of cigarettes per day: ____ # of years: ____

If no, did you previously smoke? ___Yes ___ No If yes, # of cigarettes per day: ____ #of years: ____

Do you drink alcoholic beverages? ___Yes ___No If yes, how much? _____

Have you used illegal drugs in the past 2 years? ___Yes ___No

Do you now, or have you ever, belonged to a substance abuse support group? ___Yes ___No

Do you, or have you, lived next door to or very near an industrial plant? ___Yes ___No

Do you have a hobby or craft which you do at home? ___Yes ___No

Do you use pesticides around your home or garden? ___Yes ___ No

---

Occupational History

Company: _____

Job: _____

Please List most recent job first, and then work backwards in time:

Approximate Dates	Employer Name and Location	Known Health Hazard Exposure

1. Have you ever been rejected or uprated for insurance because of your health? ___Yes ___No
2. Have you been rejected from employment, or the Armed Forces, because of health? ___Yes ___No
3. Has your work ever been limited or restricted because of health? ___Yes ___No
4. Have you ever filed a Workers Compensation claim? ___Yes ___No
5. Have you ever received benefits from a Workers Compensation claim? ___Yes ___No
6. Have you lost more than five consecutive days from work, in the past three years, because of illness or injury? ___Yes ___No
7. Do you have a condition requiring a special work assignment or work aids? ___Yes ___No
8. Have you developed hearing problems from noise exposure? ___Yes ___No
9. Have you had problems due to work with vibrating tools? ___Yes ___No

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10. Have you had occupational radiation exposure? ___Yes ___No

11. Have you had problems because of exposure to solvents, fumes, chemicals, dust, or latex? ___Yes ___No

12. Have you had problems with any occupational materials irritating to you? ___Yes ___No

If Yes, please explain: _____

_____

_____

_____

_____

To the best of my knowledge, I certify that the above answers are true and complete.

Signature: _____ Date: _____

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JOB: _____

EMPLOYER: _____

PHYSICAL EXAMINATION:

NAME: _____ DATE: _____

DATE OF BIRTH: _____

VITAL SIGNS: HGT: _____ WT: _____ B/P: _____ PULSE _____

URINALYSIS: PROTEIN: _____ GLUCOSE: _____

	WITHOUT GLASSES			WITH GLASSES/CONTACTS		
VISION BOTH:	20/_____	RIGHT 20/_____	LEFT: 20/_____	BOTH: 20/_____	RIGHT: 20/ _____	LEFT: 20/_____

COLOR BLIND (ISHIHARA): PLATE 1 2 3 4 5 6 7 8 9 10 11

NORMAL _____

ABNORMAL _____

	500 Hz			1000 Hz			2000Hz			4000Hz		
HEARING: RIGHT:	20	25	40	20	25	40	20	25	40	20	25	40
LEFT:	20	25	40	20	25	40	20	25	40	20	25	40

WHISPER TEST: AD _____ AS _____

SIGNATURE: _____

General Appearance:	Normal	Mental Status:	Normal
Skin:	Normal	Abd:	Normal:
HEENT:	Normal	Ing/Hernia:	Normal
Neck:	Normal	Exts:	Normal
Thorax:	Normal	Neuro:	Normal
Heart:	Normal	Reflexes:	Normal

COMMENTS/ SUMMARY:

Signature of Medical Provider: _____

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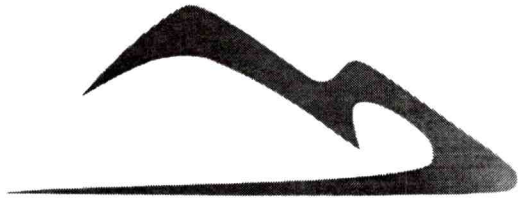

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NAME: _____ **DATE OF EXAM**_____

MEDICAL RECOMMENDATIONS:

- ○ Able to perform this job without accommodations:
- ○ Drug Screen
  - ○ Negative
  - ○ Pending Drug Screen Results
  - ○ Positive for _____

- ○ Limited due to physical and health status as follows:
  - ○ Ground level work only
  - ○ No hazardous machinery
  - ○ No driving motor vehicles
  - ○ Avoid skin irritants
  - ○ No heavy lifting over 45 lbs
  - ○ Moderate lifting 15-45 lbs
  - ○ Avoid lung irritants
  - ○ Other_____
- ○ Acknowledgement of physical defect required: defect is_____

- ○ Employable for specific job: no transfer to another job or area without medical approval.
- ○ Employable after corrected medical condition.
- ○ Employable with reasonable accommodation.

- ○ Not recommended for employment due to medical condition.

Comments:_____

_____ Date: _____

Signature of Medical Provider

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