

PHYSICAL EXAMINATION FORM

NAME:		CIVIL STATUS:		DATE EXAMINED:	
POSITION:		DATE OF BIRTH:		AGE:	SEX:
NATURE OF EXAMINATION: () Pre-employment () Annual Others: _____					
PRESENT SYMPTOMS:					
PAST DISEASES AND OPERATIONS:					
PERSONAL FAMILY HISTORY:					
HABITS:		Dietary Problems () Yes () No		Drinks Alcohol () Yes () No Smoking Cigarettes () Yes () No	
		Cholera-Typhoid () Yes () No		Tetanus () Yes () No	
Date: _____			Date: _____		

Review of Symptoms by Systems	SYMPTOMS		REMARKS
	NONE	POSITIVE	
1. Eyes, Ears, Nose & Throat			
2. Cardio Pulmonary			
3. Digestive			
4. Genito Urinary			
5. Musculo Skeletal & Articular			
6. Reproductive			
7. Nervous			
8. Dermatological			

EXAMINATION:

Height _____ cms Weight _____ lbs BP _____ mmHG

Vision: R _____ L _____

FINDINGS (Cross out any note done)	NORMAL	POSITIVE	REMARKS
1. General Appearance			
2. Skin			
3. Head & Scalp			
4. Eyes Ophthalmic Exam			
5. Nose & Sinuses			
6. Mouth & Teeth			
7. Throat, Pharynx & Tonsils			
8. Neck – Nodes, Thyroid & Vessels			
9. Breast			
10. Chest & Lungs			
11. Cardio-Vascular System			
12. Abdomen, Liver & Spleen			
13. Back			
14. Anus, Rectum			
15. Genitals & Inguinals			
16. Extremities			
17. Reflexes			
18. Others			

MEDICAL EXAMINATION RATING SYSTEM

RECOMMENDATION:

☐ Class A – Physically fit for any work

☐ Class B – Physically under-developed or with correctible defects (error of refraction, dental caries, defective hearing, and other similar defects) but otherwise fit to work

☐ Class C Employable but owing to certain impairments or conditions (heart disease, hypertension, anatomical defects) requires special placement or limited duty in a specified or selected assignment requiring follow up treatment/periodic evaluation.

☐ Class D – Unfit or unsafe for any type of employment (active PTB, advanced heart disease with threatened failure, malignant hypertension, and other similar illnesses)

Other Remarks: _____

I voluntarily consent to a physical examination designed solely to determine my physical fitness to perform the duties of the position that I have been offered. I understand that I will receive a copy of the physical examination and that I may also provide the examiner with additional information related to my ability to perform the duties of the position. I further certify that all information I have disclosed are true to the best of my knowledge and any false statements or misleading information may disqualify or invalidate my application for employment.

I give my consent to this clinic and its officially designated physicians and staff to furnish the results of this examination to my potential employers or authorized representatives.

Signature of Applicant

Examining Physician Name and Signature
License No _____