Non-DOT Physical – Patient History

Please complete the following page as accurately as possible for your physical.

Name: _____ DOB: _____

Company: _____ Job Title: _____

Have you ever had any of the following:

	Y	N		Y	N		Y	N
Allergy or Hay Fever	☐	☐	Epilepsy (Seizures)	☐	☐	Rheumatic fever	☐	☐
Anemia	☐	☐	Eye Injury or Disease	☐	☐	Rheumatism or Arthritis	☐	☐
Asthma	☐	☐	Fainting/Dizzy Spells	☐	☐	Sinus Trouble	☐	☐
Backache or back injury	☐	☐	Head Injury	☐	☐	Skin Disease/Rash	☐	☐
Herniated or bulging Discs	☐	☐	Heart Trouble	☐	☐	Surgery	☐	☐
Blood Clot	☐	☐	Hernia	☐	☐	Ulcer/Heartburn	☐	☐
Bowel/Bladder Disorder	☐	☐	High Blood Pressure	☐	☐	Varicose Veins	☐	☐
Broken Bone or Dislocation	☐	☐	Kidney Trouble	☐	☐	Weight Changes	☐	☐
Coughing Up Blood	☐	☐	Sleep Disorders	☐	☐	Tobacco Use	☐	☐
Depression/ Other Psychiatric	☐	☐	Loss of Sensation	☐	☐	Alcohol Use	☐	☐
Diabetes	☐	☐	Lung Trouble	☐	☐	Drug Use	☐	☐
Ear Trouble	☐	☐	Prolonged Cough	☐	☐	Other (write below)	☐	☐

_____

Explanation of "YES" answers:

_____

_____

Allergies to Medications:

_____

Current Medications:

_____

_____

_____

Last Tetanus: _____ (if not sure write unknown)

FEMALES ONLY: Are you Pregnant? ☐ Yes ☐ No

I understand that any intentional incorrect statement or omission may be sufficient grounds for my dismissal.

Patient Signature: _____ Date: _____

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WorkFitMedical
Occupational Health Services

Non-DOT Physical

Name: _____ DOB: _____

Company: _____ Job Title: _____

Height: _____ inches Weight: _____ pounds

Blood Pressure: _____/_____ Pulse: _____ O2 Sat: _____

Respirations: _____ Temperature: _____

Vision:

Right: _____ Left: _____ Both: _____ Corrective Lenses? ☐ Yes ☐ No

Optional Color Vision: Able to distinguish between Red/Yellow/Green? ☐ Yes ☐ No

Urinalysis (optional):

SG: _____ Protein: _____ Glucose: _____ Blood: _____

Clinical Examination

(N=Normal, A=Abnormal, NE= Not Examined)

	N	A	NE		N	A	NE
General Appearance	☐	☐	☐	Upper Extremities	☐	☐	☐
Head	☐	☐	☐	Lower Extremities	☐	☐	☐
Eyes	☐	☐	☐	Back	☐	☐	☐
Ears	☐	☐	☐	Vascular System	☐	☐	☐
Nose/Mouth/Throat	☐	☐	☐	Lymphatic System	☐	☐	☐
Neck	☐	☐	☐	Neurological	☐	☐	☐
Lungs	☐	☐	☐	Hernia	☐	☐	☐
Heart	☐	☐	☐	Other:	☐	☐	☐
Abdomen	☐	☐	☐				

Medical Practitioner Review:

_____

_____

_____

This employee meets job requirements: ☐ Yes ☐ No ☐ Other

The patient has been evaluated and is medically qualified to perform the essential duties required by their job. The patient shows no obvious signs or symptoms of illness or physical limitations that would impair their ability to safely fulfill their work responsibilities: ☐ Yes ☐ No

Provider name: _____ Date: _____

Provider Signature: _____

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