PRIMO HEALTHCARE SERVICES

Physical

Name: _____ DOB: _____
(Last) (First) (M.I.)

Address: _____ Phone: _____
(Street) (City) (State) (Zip)

Social Security #: _____ Sex: _____ Marital Status: _____
Emergency Contact: _____ Relationship: _____
Address: _____ Phone: _____

Clinical Evaluation

Hgt: _____ Wgt: _____ B/P: _____ Temp: _____ Pulse: _____ Resp: _____

Normal	Abnormal	"NE" if not evaluated	Comments/Findings
		EYES	
		NOSE	
		EARS	
		MOUTH/THROAT	
		HEAD/NECK	
		THYROID	
		CHEST/LUNGS	
		HEART	
		VASCULAR SYSTEM	
		BREASTS	
		ABDOMEN	
		HERNIA	
		UPPER EXTREMITIES	
		LOWER EXTREMITIES	
		BACK/SPINE	
		SKIN	
		LYMPH NODES	
		NEURO	

Personal History

Alcohol □ Yes □ No ***Tobacco*** □ Yes □ No ***Former Smoker*** □ Yes □ No
Prescription/Non-Prescription Drugs □ Yes □ No

List Present Medications:

_____
_____
_____
_____
_____

List Injuries, Illnesses, Hospitalizations, & Surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

PRIMO
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Physical

Vision □ Wears Glasses or Contacts □ Nearsightedness □ Farsightedness

□ Color Blindness □ Cataracts □ Retinal Problems

Allergies: _____

Significant Health Issues: _____

Do you have any of the following: *(If yes, give year of occurrence)*

Recurrent Cough	□ Yes	□ No _____	Urine Problems	□ Yes	□ No _____	Eczema/Skin Problems	□ Yes	□ No _____
Coughing Blood	□ Yes	□ No _____	Tumor or Cancer	□ Yes	□ No _____	Drug/Alcohol Problems	□ Yes	□ No _____
Shortness of Breath	□ Yes	□ No _____	Blood Transfusion	□ Yes	□ No _____	Latex/Chem. Sensitivity	□ Yes	□ No _____
Emphysema	□ Yes	□ No _____	Anemia/Blood Disorder	□ Yes	□ No _____	Vomiting of Blood	□ Yes	□ No _____
Asthma	□ Yes	□ No _____	Unplanned Weight Loss	□ Yes	□ No _____	Hepatitis A	□ Yes	□ No _____
Abnorm. Chest X-Ray	□ Yes	□ No _____	Diabetes	□ Yes	□ No _____	Hepatitis B	□ Yes	□ No _____
TB History	□ Yes	□ No _____	Convulsions/Fits	□ Yes	□ No _____	Hepatitis C	□ Yes	□ No _____
Dizzy Spells	□ Yes	□ No _____	Headaches	□ Yes	□ No _____	Numbness/Tingling	□ Yes	□ No _____
Chest Pain	□ Yes	□ No _____	Paralysis	□ Yes	□ No _____	Emotional/Mental Illness	□ Yes	□ No _____
Irregular Heart Beat	□ Yes	□ No _____	Back Trouble	□ Yes	□ No _____	Venereal Disease	□ Yes	□ No _____
Heart Trouble	□ Yes	□ No _____	Arthritis	□ Yes	□ No _____	Gallbladder	□ Yes	□ No _____
High B/P	□ Yes	□ No _____	Joint Pain	□ Yes	□ No _____	Testit./Prostate Problems	□ Yes	□ No _____
Fainting Spells	□ Yes	□ No _____	Broken Bones	□ Yes	□ No _____	Kidney/Bladder Problems	□ Yes	□ No _____
Frequent Indigestion	□ Yes	□ No _____	Osteoporosis	□ Yes	□ No _____	Breast Lump	□ Yes	□ No _____
Rectal Bleeding	□ Yes	□ No _____	Ear Trouble	□ Yes	□ No _____	Abnormal Period	□ Yes	□ No _____
Jaundice	□ Yes	□ No _____	Eye Trouble	□ Yes	□ No _____	Menstrual Cramps	□ Yes	□ No _____
Leg Pain	□ Yes	□ No _____	Nose Trouble	□ Yes	□ No _____	Last Period (date): _____		
Ankle Swelling	□ Yes	□ No _____	Throat Trouble	□ Yes	□ No _____	Other: _____		
Hernia	□ Yes	□ No _____	Wheezing	□ Yes	□ No _____			

Employment History

Occupation: _____

Previous work-related injury/illness? □ Yes □ No

Type: _____

Have you ever been rejected for employment, military service, or insurance for health reasons? □ Yes □ No

Why? _____

Have you ever received Workmen's Compensation benefits? □ Yes □ No

Describe: _____

Do you require accommodation/special assistance of any kind? □ Yes □ No

Describe: _____

Do you use any aids or assistive devices (prostheses)? □ Yes □ No

Describe: _____

Patient is physically able to perform his/her job without accommodation(s) and is free of communicable disease.

Examining Physician: _____ **Date:** _____

Examining Physician Signature: _____