Kids Central, Inc.
Occupational Physical Exam Form

Exam Date: ____/____/____ Time _____:____ am/pm

( ) Pre-Employment
( ) Annual
( ) Other

Name: _____ Social Security #: _____

Home Phone: _____ Birthdate: ____/____/____ Sex: ( ) M ( ) F

Employer: _____ Job Title: _____

Notes: _____

PATIENT TO COMPLETE:

Please list any allergies you may have: _____

Please list all current medications: _____

HAVE YOU EVER HAD:

_____Asthma	_____Kidney problems	_____Nervous stomach	_____Head injury
_____Rheumatic fever	_____Tuberculosis	_____Syphilis/VD	_____Gonorrhea
_____Diabetes	_____Muscular Disease	_____Psychiatric disorder	_____Heart problems
_____Gastrointestinal problems	_____Seizures, fits, convulsions	_____Fainting	_____Hepatitis
		_____High blood pressure	_____Hernia
_____Extensive confinement for illness	_____Shortness of breath	_____Chest pain	_____Arthritis
		_____Carpal tunnel syndrome	_____Back injury

_____Permanent impairment from injury/illness

_____Other_____

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE: _____
_____

PHYSICAL EXAMINATION:

Vision: OD_____ OS_____ OU_____
Hearing: Right_____ Left_____

Height: _____
Weight: _____
B.P. _____
Pulse _____
Resp. _____
L.M.P. _____

Tendinitis Signs:

Pass	Fail		Pass	Fail	
( )	( )	Tinels Right	( )	( )	Tinels Left
( )	( )	Phalens Right	( )	( )	Phalens Left
( )	( )	Finkelsteins Right	( )	( )	Finkelsteins Right

Flexibility Signs:

Pass	Fail	
( )	( )	Toe Touch _____ inches from ground
( )	( )	Leg Raise
( )	( )	Sit up

Notes: _____

Norm	Abnorm		Explanation of abnormal findings
( )	( )	General Appearance	_____
( )	( )	Skin	_____
( )	( )	Ears	_____
( )	( )	Eyes	_____
( )	( )	Head	_____
( )	( )	Neck	_____
( )	( )	Lungs	_____
( )	( )	Thorax	_____
( )	( )	Heart	_____
( )	( )	Abdomen _____	Hernia? _____
( )	( )	Spine	_____
( )	( )	Extremities	_____
( )	( )	Reflexes: Rhomberg _____	Pupils _____

Knee jerks:

Right ( ) Normal ( ) Increased ( ) Absent _____

Left ( ) Normal ( ) Increased ( ) Absent _____

GENERAL COMMENTS: _____

_____

_____

In my opinion, this employee is:

( ) Able to perform the essential functions of his/her job

( ) Able to perform the essential functions of his/her job with the following restrictions:

_____

_____

_____

( ) Performing his/her job would pose a direct threat to this employee or others in the workplace. As per Section 1630.2(r) under the Americans with Disabilities Act, only assessments that directly impact the performance of essential job functions were considered in my opinion.

PATIENTS WITH ABNORMAL FINDINGS MUST SIGN BELOW:

I have been notified of my evaluation results indicating the above findings. I have been advised by the Occupational Medicine Physician to notify my family physician with a copy of these results as soon as possible.

X _____ **(Employee's signature)**

EXAMINED BY: _____ **(Physician's Signature)**

_____ **Physician's Printed Name**

_____ **Address**

_____

_____ **Telephone Number**