



FortMED Medical Clinics

Patient Identification

HISTORY AND PHYSICAL EXAMINATION

Pre-Employment Annual Other _____

MEDICAL HISTORY: Place a (✓) next to illness / condition you have or had. Explain below

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Polio | <input type="checkbox"/> Any compensation or Insurance |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Rheumatic Fever | Benefits for injury |
| <input type="checkbox"/> Asthma or Bronchitis | <input type="checkbox"/> Hemorrhoids (Piles) | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Surgery (Specify) |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Heredity / Familial Disease | <input type="checkbox"/> Skin Disease | _____ |
| <input type="checkbox"/> Bleeding Tendencies | Specify: _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Previous Hospitalization (Specify) |
| <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinusitis | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diarrhea or Dysentery | <input type="checkbox"/> Kidney / Bladder Problems | <input type="checkbox"/> Typhoid Fever | _____ |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Ulcer (Stomach or Duodenal) | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Vaccinations | Females: |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine / Headache | <input type="checkbox"/> Wear Corrective Lens | <input type="checkbox"/> Dymenorhea |
| <input type="checkbox"/> Goiter (Thyroid) | <input type="checkbox"/> Neuralgia / Neuritis | <input type="checkbox"/> Smoker / Pack Years _____ | <input type="checkbox"/> Date of last menstrual |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Alcohol / Beverage Drinker | _____ |
| | <input type="checkbox"/> Pneumonia | Average Amount _____ | G _____ P _____ |

EXPLANATIONS:

I certify that my answer to the above questions are true and I give permission for a Physical Examination.

Signature

PHYSICAL EXAMINATION

Date & Time of Examination: _____ Ht _____ Wt _____ T _____ P _____ R _____ BP _____

CHECK (✓) if normal (✗) if abnormal (Comment below)

1 Head	6 Dental	11 Abdomen	16 Neurological
2 Eyes	7 Neck / Thyroid	12 Genitals (Male)	17 Rectal
3 Ears	8 Thorax / Lungs	13 Genitals (Female)	18 Deformities
4 Nose	9 Cardiovascular	14 Mental Status	19 Others
5 Mouth	10 Breasts	15 Skin	

* Attach Autorefraction Results Here

Please comment on any abnormal findings and Recommendations.

_____, M.D.
Examining Physician

(Continue on reverse side, if necessary)

Liscence No. _____

TEST RESULTS

URINALYSIS	HEMOGLOBIN OR HEMATOCRIT	FECALYSIS
Alb _____ Sugar _____ Micro _____	_____ gm% _____ %	_____

(Original Reports are
Filed in Medical record)

X-Ray Findings: _____

Others: _____