Form A

MIDWESTERN UNIVERSITY OPTI - AZCOM

PRE-EMPLOYMENT HISTORY AND PHYSICAL

Name ____________________________ Birth Date _________Age _____

Department _______________________ Position ___________________

MEDICAL HISTORY

Childhood Illnesses & Immunizations

Please check the following childhood diseases & immunizations you have had.
Note: An official copy of your immunizations should be included with this form when returning it to Midwestern University.

	Yes	No		Yes	No
a. Measles	_____	_____	e. Diphtheria/Tetnus Toxoid	_____	_____
b. Mumps	_____	_____	f. Polio Oral	_____	_____
c. Chickenpox	_____	_____	g. Rubella	_____	_____
d. Scarlet Fever	_____	_____	h. Hepatitis	_____	_____

Hospitalizations

Have you been hospitalized for any reason (i.e. medical trauma, injury, mental illness, chemical dependency, operation, pregnancy)?

Hospital			
Year			
Reason			

Past Medical History

Please place an (X) next to any of the following conditions that you have or had in the past.

____ Cancer

____ Allergies or Asthma

____ Diabetes

____ Tuberculosis

____ Nervous Disorder

____ Epilepsy

____ Back injuries

____ Recent travel outside USA

____ Anemia

____ Heart Disease

____ Bleeding Tendencies

____ Stroke

____ High Blood Pressure

____ Needle Sticks

____ Recent Immigration

____ Other

Family Medical History

Please check the items that are pertinent to your family (children, brother, sister, parents, grandparents) medical history.

Family	Living Age	Deceased Cause	Deceased Age
Mother			
Father			
Sister (s)			
Brothers (s)			
Children			

Please place an (X) next to any of the following conditions that anyone in your immediate family has ever had.

____ Anemia ____ High Blood Pressure ____ Cancer

____ Allergies or Asthma ____ Heart Disease ____ Stroke

____ Diabetes ____ Bleeding Tendencies ____ Epilepsy

____ Tuberculosis ____ Nervous Disorder ____ Other

Illnesses & Medical Problems

Mark the problems you have or have had during the past year.

Ear & Eyes	Yes	No	Do Not Write Here
1. Visual problems	___	___	__________
2. Eye pain	___	___	__________
3. Eye infection	___	___	__________
4. Hearing problem	___	___	__________
5. Ear infection	___	___	__________

Respiratory System			
1. Nose bleeds	___	___	__________
2. Constantly running nose	___	___	__________
3. Wheezing	___	___	__________
4. Coughing	___	___	__________
5. Coughing up blood	___	___	__________
6. Severe sweats at night	___	___	__________

Genitqurinary			
1. Hernia/rupture	___	___	__________
2. Blood while urinating	___	___	__________
3. Pain while urinating	___	___	__________
4. Kidney stones	___	___	__________
5. Bladder infection	___	___	__________
6. Painful menstrual periods	___	___	__________
7. Vaginal discharge	___	___	__________
8. Irregular or heavy bleeding	___	___	__________

	Yes	No	Do Not Write Here
9. Yearly P.A.P./pelvic exams	___	___	__________

10. Last menstrual period ___ ___ __________

Date ________________

Cardiovascular

1. Chest pain	___	___	__________
2. Shortness of breath	___	___	__________
3. Palpitations	___	___	__________
4. Ankle swelling	___	___	__________

Gastrointestinal

1. Heartburn	___	___	__________
2. Indigestion	___	___	__________
3. Poor appetite	___	___	__________
4. Bloody stools	___	___	__________
5. Constipation	___	___	__________
6. Ulcers	___	___	__________

Musculoskeletal

1. Joint pain	___	___	__________
2. Broken bones	___	___	__________
3. Joint swelling	___	___	__________
4. Chronic backache	___	___	__________

Mark the appropriate answers:

	Yes	No		Yes	No
1. Frequent severe headaches	___	___	Nervous condition	___	___
2. Dizzy spells	___	___	Weight changes	___	___
3. Numbness or tingling	___	___	Do you smoke?	___	___
4. Convultion/"fits"	___	___	Do you drink alcohol	___	___
5. Rashes	___	___	Do you exercise	___	___

Do you have any other health problems: Yes ____ No ____

If yes, please explain ____

____

General Health: Excellent ____Good ____ Poor ____

Allergies: Do you have any allergies to medicine? Yes ____ No ____

If yes, please list____

____

Medications: Do you take any medications or drugs regularly? Yes ____ No ____

If yes, please list ____

____

I hereby state that the information given herein is accurate and true to the best of my knowledge and that the Medical Center employees, including Medical Center Health Services, will not be held responsible for the result of misrepresented or withheld facts. I also state that I am physically capable of performing the responsibilities related to my employment and should I be unable to do so, I understand that such limitations may affect my employment status. I hereby give my consent to a physical examination and such tests consistent with the job description and the physical requirements necessary for the position for which I am seeking employment.

Date ___________________ Signature of Applicant __________________________________

PLEASE DO NOT WRITE IN THE SECTION BELOW

Blood Pressure: RA ____________________ Weight _______ Height ______

LA _____________________ Vision: OD 20/

Temperature: ______________ Oral Vision: OS 20/

Pulse: Rate _______ Rhythm ___________ Color Vision ________________________

Respiration: Rate _______ Rhythm _______ Rhythm ___________________________

General Appearance: ____

____

____

Eyes	**Normal**	**Abnormal**	**Heart/Vessels**	**Normal**	**Abnormal**
Lid	______	_______________	Rate	______	_____________
Sclera	______	_______________	Rhythm	______	_____________
Pupils	______	_______________	Pulses	______	_____________
Fundl	______	_______________			
Ears			**Abdomen**		
Hearing	______	_______________	Tenderness	______	_____________
Canal	______	_______________	Organs	______	_____________
Drum	______	_______________	Masses	______	_____________
			Hernia	______	_____________

Nose			**Rectum**		
Septum	______	______________	Hemorrhoid	______	____________
Mucosa	______	______________	Masses	______	____________
	Normal	**Abnormal**		**Normal**	**Abnormal**
			Sphincter	______	____________
Mouth/Throat			**GU Male**		
Tonsils	______	_____________	Penis	______	____________
Tongue	______	_____________	Testicles	______	____________
Gums	______	_____________	Prostate	______	____________
Teeth	______	_____________			
Chest/Lungs			**Gyne**		
Sounds	______	_____________	Labia	______	____________
Expansion	______	_____________	Adnexa	______	____________
Breast	______	_____________	Cervix	______	____________
			Vagina	______	____________

Extremities & Back

Back	Normal _________________	Abnormal _______________________
Extremities	Normal _________________	Abnormal _______________________
Muscle Strength	Normal _________________	Abnormal _______________________
Arms	Normal _________________	Abnormal _______________________

Assessment	_________________________________	Lab	____________________________
	_________________________________		____________________________
Plan	_________________________________	PPD	___________________________
	_________________________________	CXR	___________________________
	_________________________________		___________________________

Recommend Employment Yes ____ No ____

____ Physician Signature

________________________ Date

____ Nurse Signature

________________________ Date