REDDY MEDICAL GROUP, LLC
D/B/A Reddy Urgent Care

Reddy Urgent Care Pre-Employment Physical Form

Please PRINT all answers, do NOT leave blank spaces, and complete form PRIOR to seeing examining provider.

EMPLOYER: _____ **JOB DESCRIPTION/TITLE:** _____

Last Name: _____ **First Name:** _____ **MI:** _____ **Date:** ____/____/____

Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

FREQUENT HEADACHES:	YES ☐	NO ☐	EYE OR EAR INFECTIONS:	YES ☐	NO ☐	SINUS TROUBLE:	YES ☐	NO ☐
THYROID PROBLEMS:	YES ☐	NO ☐	FREQUENT COLDS:	YES ☐	NO ☐	LUMPS or TUMORS in NECK:	YES ☐	NO ☐
ASTHMA:	YES ☐	NO ☐	SPITTING UP BLOOD:	YES ☐	NO ☐	CHRONIC COUGH:	YES ☐	NO ☐
LUNG TROUBLE:	YES ☐	NO ☐	TUBERCULOSIS:	YES ☐	NO ☐	SHORTNESS OF BREATH:	YES ☐	NO ☐
CHEST PAINS:	YES ☐	NO ☐	HEART MURMUR:	YES ☐	NO ☐	SWELLING OF ANKLES:	YES ☐	NO ☐
LOW BLOOD PRESSURE:	YES ☐	NO ☐	HEARTBURN:	YES ☐	NO ☐	FREQUENT DIARRHEA:	YES ☐	NO ☐
ABDOMINAL PAINS:	YES ☐	NO ☐	LIVER TROUBLE:	YES ☐	NO ☐	HEPATITUS or JAUNDICE:	YES ☐	NO ☐
PLIES and/or HEMORRHOIDS:	YES ☐	NO ☐	HERNIA or RUPTURE:	YES ☐	NO ☐	KIDNEY STONES:	YES ☐	NO ☐
BROKEN BONES:	YES ☐	NO ☐	BACK PAIN or SURGERY:	YES ☐	NO ☐	ARTHRITIS:	YES ☐	NO ☐
DEFORMITIES OF JOINTS:	YES ☐	NO ☐	DEFORMITIES OF BONES:	YES ☐	NO ☐	MISSING FINGERS or TOES:	YES ☐	NO ☐
RUPTURED DISCS IN BACK:	YES ☐	NO ☐	SKIN RASHES:	YES ☐	NO ☐	HEAD INJURY:	YES ☐	NO ☐
EPILEPSY or FITS:	YES ☐	NO ☐	FREQUENT DIZZINESS:	YES ☐	NO ☐	PARALYSIS:	YES ☐	NO ☐
LOSS OF MEMORY:	YES ☐	NO ☐	DIABETES or HIGH BLOOD SUGAR:	YES ☐	NO ☐	ALLERGIES:	YES ☐	NO ☐
ALLERGIC REACTION TO FOOD:	YES ☐	NO ☐	ALLERGIC REACTION TO DRUGS:	YES ☐	NO ☐	ANEMIA:	YES ☐	NO ☐
DEPRESSION:	YES ☐	NO ☐	ANXIETY or PANIC ATTACKS:	YES ☐	NO ☐	CHANGE IN ACTIVITY LEVEL:	YES ☐	NO ☐
HIGH BLOOD PRESSURE:	YES ☐	NO ☐	CHRONIC BRONCHITIS:	YES ☐	NO ☐	MUSCLE PAIN:	YES ☐	NO ☐
SLEEPING PROBLEMS:	YES ☐	NO ☐	LOSS OF CONSCIOUSNESS:	YES ☐	NO ☐	CARPAL TUNNEL SYNDROME:	YES ☐	NO ☐
NUMBNESS or TINGLING OF HANDS or FEET	YES ☐	NO ☐	HOSPITALIZATION(S):	YES ☐	NO ☐	OTHER:	YES ☐	NO ☐

DOB: ____/____/____ **Sex:** **Male** ☐ **Female** ☐

DO YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST ANY OF THE FOLLOWING CONDITIONS? Please do NOT leave blank spaces.
If you answered YES to having been hospitalized, please complete the following section with the MOST RECENT hospital stay listed first.

HOSPITAL NAME: **TREATED FOR:** **Date(s):**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

In the PAST YEAR, have you missed time from work for ANY reason? YES ☐ **NO** ☐ **If YES, please explain below:**

_____
_____
_____
_____

Do you SMOKE? YES ☐ **NO** ☐ **IF YES, what do you smoke?** _____ **How many per day?**_____
How many years?_____

Do you consume ALCOHOL? YES ☐ **NO** ☐ **IF YES, how many drinks do you consume at each sitting?** _____
How many days per week _____

What do you drink? BEER ☐ **WINE** ☐ **HARD LIQUOR** ☐ **OTHER** ☐

Do you currently have a primary healthcare provider? YES ☐ **NO** ☐

If YES, what is your primary healthcare provider's name?_____ **Phone Number:** (____)-_____-_____

Address:_____**City:**_____**State:**_____**Zipcode:**_____

Have you been treated in the past year? Yes ☐ **No** ☐ **If yes, please explain below:**

_____
_____
_____
_____

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Medication: (Name & Dosage)		Medication: (Name & Dosage)		Medication: (Name & Dosage)
1.		6.		11.
2.		7.		12.
3.		8.		13.
4.		9.		14.
5.		10.		15.

Are you currently taking any prescribed or over-the-counter medications, supplements, vitamins, herbal products? YES ☐ NO ☐

If YES, please list below:

DATE OF YOUR LAST TETANUS SHOT:_____/_____/_____ Have you received the HEPATITIS B VACCINE? YES ☐ NO ☐

I give permission to the examining healthcare provider at Athens Reddy Urgent Care to forward any abnormal findings to my healthcare provider. I understand and acknowledge that I am solely responsible for following up with my own healthcare provider on any abnormal findings that arise during the pre-employment physical conducted by the examining provider at Reddy Urgent Care. I understand and acknowledge that Reddy Urgent Care does not provide follow-up treatment for such findings.

PRINT NAME:_____ SIGNATURE:_____ Date:____/____/_____

The information provided in this form is strictly confidential and will remain in the Athens Reddy Urgent Care Center and _____ confidential files. They may be seen by ONLY the examining healthcare provider, nurses in attendance, and administrative personnel reviewing the form for quality assurance purposes. I hereby declare the answers given are to the best of my knowledge.

PRINT NAME:_____ SIGNATURE:_____ Date:____/____/_____

The Following is to be completed by the REDDY MEDICAL GROUP/REDDY URGENT CARE Provider:

Name:_____ DOS:_____/_____/_____

General Appearance:

HYGIENE:	Excellent ☐	Good ☐	Fair ☐	Poor ☐
BODY TYPE:	Obese ☐	Average ☐	Thin ☐	Other ☐ _____
MENTAL STATE:	Distressed ☐	No Distress ☐	Other ☐ _____	~~N/A~~

Vital Signs:

BP: /	Pulse:	Respirations:	Height:	Weight:	Visual Acuity w/ Correction? Yes ☐ No ☐ If YES, type of correction used?:_____	Right Eye: 20/	Left Eye: 20/	Both Eyes: 20/

Lab Data:

Sugar:	Acetone:	Albumin:

System:

SYSTEM:	NORMAL:	ABNORMAL:	COMMENTS:
HEAD	☐	☐	
EYES	☐	☐	
EARS	☐	☐	
NOSE	☐	☐	
MOUTH	☐	☐	
NECK	☐	☐	
CHEST	☐	☐	
HEART	☐	☐	
LUNGS	☐	☐	
ABDOMEN	☐	☐	
EXTREMITIES	☐	☐	
SPINE	☐	☐	
NEURO	☐	☐	
SKIN	☐	☐	
PSYCH	☐	☐	

Additional Comments:

_____

_____

_____

_____

_____

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REDDY URGENT CARE/REDDY MEDICAL GROUP PRE-EMPLOYMENT WORK CLEARANCE FORM

*APPROVED **WITHOUT** RESTRICTIONS:* ☐

*APPROVED **WITH** RESTRICTIONS:* ☐

***NOT** APPROVED:* ☐

*REASON (**Only needed if "Approved With Restriction(s)" or "Not Approved"**):*

_____

_____

_____

_____

FOLLOW UP REQUIRED? YES ☐ ***NO*** ☐

If YES, schedule follow up appointment in _____ from today's date.

_____

Examining Provider (PRINT NAME)

_____/_____/_____

Examining Provider Signature *Date*