

Employee Health Examination Record

Name _____ M S W D Date of Birth _____

Notify in case of emergency - Name _____ Relationship _____

Address _____ Tele. No. _____

Street City State Zip

Applicant:	Have you had any of the following?		(Please Check)	
	yes	no		
Diabetes	—	—	Fainting spells	—
Operations	—	—	Epilepsy	—
Fractures	—	—	Mental Disease	—
Head injury	—	—	Jaundice	—
Back injury	—	—	Rheumatism	—
Other injuries	—	—	Asthma	—
Chronic back pain	—	—	Sinus trouble	—
Tuberculosis	—	—	Skin disease	—
Heart trouble	—	—	Hernia	—
Stomach trouble	—	—		—

I have read the above and declare that I have had no injury, illness or ailment other than as specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

Signature _____

- _____ Ears
- _____ Eyes
- _____ Teeth
- _____ Nose and throat
- _____ Skin
- _____ Scars
- _____ Heart
- _____ Lungs
- _____ Abdomen
- _____ Hernia
- _____ Extremities
- _____ Blood pressure
- _____ Menstrual History

Temperature _____ Pulse _____ Respirations _____

Date _____ Examining Physician _____