



1661 St. Anthony Avenue, 2nd Floor
 St. Paul, MN 55104
 (651) 842-5300 Phone
 (651) 646-0205 Fax

DATE

HISTORY & PHYSICAL

NAME	DATE OF BIRTH	SS#
STREET ADDRESS		
CITY	STATE	ZIP
COMPANY	POSITION APPLIED FOR	

**THIS EXAMINATION IS TO DETERMINE WORK CAPABILITIES ONLY.
 IT IS NOT INTENDED TO TAKE THE PLACE OF A REGULAR EXAMINATION BY YOUR PRIVATE HEALTH CARE PROVIDER**

HEALTH HISTORY: please complete the following illnesses/injuries checklist below.

HAVE YOU EVER HAD...	YES	NO	YEAR	HAVE YOU EVER HAD...	YES	NO	YEAR
Head injury, skull fracture, whiplash				Gallstones			
Frequent headaches, dizziness, fainting spells				Kidney problem, frequent urination			
Mental, nervous, brain problem				Hepatitis or jaundice			
Convulsions, epilepsy, black-outs				Liver problem			
Asthma, allergies (food, chemical, medications)				Hernia or rupture			
Vision loss, blindness, color blindness				Foot or ankle problem			
Ear problems, decreased hearing				Varicose veins, leg ulcers			
Diabetes				Hand, wrist, elbow problem			
Frequent nosebleeds				Stiff joints; trick shoulders or knees			
Frequent difficulty swallowing				Shoulder problem (rotator cuff, etc.)			
Hoarseness				Back injury, strain, herniated disc, recurring ache			
Rheumatic fever				Bursitis, tendonitis			
Chronic bronchitis, cough, pneumonia				Rheumatism, arthritis, gout			
Tuberculosis, spitting blood				Hospitalizations for illness or injury			
Chest pain, shortness of breath				Anemia or bleeding problems			
Swelling of legs or ankles				Rash from contact or allergy			
High blood pressure, stroke				Fractures of any degree			
Stomach trouble, ulcers				Scars or identifying marks			
Tumor or cancer				Muscle disorder			
Heart trouble				Do you wear contact lenses?			

Comments _____

Answer the following questions by checking “YES” or “NO.”
Please explain any “YES” answers below under “Comments.”

	YES	NO
1. Have you ever had an electrically sharp pain traveling into your fingers at any time?.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had shoulder, elbow, wrist or finger problems? (I.e. sprain, injury, dislocation, tendonitis)?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you or have you ever worn a supportive brace for your wrist, back or knee?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had any back trouble or back injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any condition that may require a special work assignment or accommodation if you are hired? (I.e. walking, bending, lifting, standing)?.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you or have you ever had swelling in your arms or legs?.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you developed hearing loss from noise exposure?.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever developed a health problem from using a vibrating tool?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever developed a health problem from exposure to chemicals, dusts or fumes?.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any physical defects or partial disability?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever received a pension, insurance payment or compensation for any work-related injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever received a Veteran Benefit due to injury?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you ever been injured in a car accident?.....	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever been evaluated or treated for chemical dependency?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you ever been advised to have a surgical operation or medical treatment that has not been done?.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you presently under the care of a physician or chiropractor?.....	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have any other health concerns not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you had injuries or illnesses in the past that happened at work?.....	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you or have you ever had numbness or tingling in the hand or been awakened at night because of pain in your hand?.....	<input type="checkbox"/>	<input type="checkbox"/>

Comments _____

PERSONAL HISTORY

20. When was your last physical, EKG, exam and/or X-rays taken? _____ Where? _____

21. Was there a reason for this exam or procedure or was it an annual exam? Please explain _____

22. Your last diphtheria tetanus booster was? (Year) _____

23. Have you completed the series or three hepatitis B injections? Yes No

24. List all medications you are currently taking _____

25. Do you or have you, smoked cigarettes or cigars? Yes No

How many a day? _____ How many years? _____

26. Do you or have you, drank alcohol? Yes No

Drinks per week? _____ How many years? _____

Comments _____

OCCUPATIONAL HISTORY

HAVE YOU EVER WORKED AT OR IN ANY OF THE FOLLOWING OCCUPATIONS?

	YES	NO		YES	NO
Asbestos			Pottery		
Brick Manufacturing			Quarry and Stone Cutting		
Car Body Repair or Lead Grinding			Radiation Materials Exposure		
Foundry			Sand Blasting		
Glass Manufacturing			Welding		
Mining					

List other past job positions _____

What types of physical demands were required of you in past work positions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Standing 7-8 hours day | <input type="checkbox"/> Fine hand movements
O Repetitive
O Change of position | <input type="checkbox"/> Close eye work |
| <input type="checkbox"/> Twisting of wrists:
O Constant
O Periodic
O Heavy
O Light | <input type="checkbox"/> Frequent lifting greater than 50 pounds | <input type="checkbox"/> Twisting of back |
| <input type="checkbox"/> Exposure to hazardous materials
<i>(i.e. chemicals, excessive heat, radiation)</i> | <input type="checkbox"/> Driving vehicle | <input type="checkbox"/> Kneeling |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Operating machinery | <input type="checkbox"/> Exposure to loud noises |

I hereby certify that I have answered the questions above to the best of my knowledge and that the answers are true and complete. I authorize Minnesota Occupational Health to release this information to my employer.

Patient X _____
Signature

_____ Date

PATIENT'S NAME		EMPLOYER	
HEIGHT	WEIGHT	PULSE	BLOOD PRESSURE (sitting)

URINALYSIS (*dip stick*)

-
- Negative
-
-
- Positive

VISION W/O GLASSES:

Distant (standard type only):

_____ R _____ L

Near vision values:

_____ R _____ L

VISION WITH GLASSES/CONTACTS:

Distant (standard type only):

_____ R _____ L

Near vision values:

_____ R _____ L

COLOR VISION:

-
- Ishihara
-
-
- Primary
-
- O N
-
- O A

ABNORMAL FINDINGS

-
- Glucose
-
-
- Protein
-
-
- Blood

	N	A	O	ABNORMAL FINDINGS
1. Development				
2. Skin				
3. Eyes				
4. Ears				
5. Nose/Sinuses				
6. Throat				
7. Teeth/Gums				
8. Thyroid gland/Neck				
9. Lymph glands				
10. Chest				
11. Lungs				
12. Heart				
13. Abdomen				
14. Inguinal rings				
15. Spine				
16. Extremities				
17. Neurological, general				
18. Personality, general				

-
- Medically recommended for position.
-
-
- Medically recommended with limitations as noted.
-
-
- Medically recommended only after correction or control of condition as noted.
-
-
- Medical recommendation reserved pending additional medical information.

INJECTIONS/SKIN TESTS

COMMENTS _____

THIS INDIVIDUAL:

-
- Has**
- been advised of the findings of this examination.
-
-
- Has not**
- been advised of the findings of this examination.

 Physician X _____
 Signature

 Date