



Physical Examination Form

Please type or print neatly.

NAME	First	Middle	Last
SOCIAL SECURITY #	<input type="text"/>	<input type="text"/>	<input type="text"/>
DATE OF EXAMINATION			<input type="text"/>
HOME ADDRESS			PHONE
CITY	STATE	ZIP	

HEALTH HISTORY

Yes	No	Yes	No	Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder
<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease, or injury
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drugs	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal	<input type="checkbox"/>	<input type="checkbox"/>	

IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN

GENERAL APPEARANCE AND DEVELOPMENT:

Good Fair Poor

VISION: For distance Right/20 Left/20 Both/20 Without corrective lenses
 With corrective lenses

Evidence of disease or injury: Right _____ Left _____

Color test: Right _____ Left _____

Horizontal field of vision: Right _____ Left _____

HEARING: Right ear _____ Left ear _____

Evidence of disease or injury: Right ear _____ Left ear _____

AUDIOMETRIC TEST: 500 HZ 1000 HZ 2000 HZ 3000 HZ 4000 HZ
 5000 HZ 6000 HZ 7000 HZ 8000 HZ

THROAT: _____

THORAX: Heart: _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after _____

Lungs: _____

PHYSICAL EXAMINATION FORM (CONT'D)

ABDOMEN: Scars _____ Abdominal masses _____ Tenderness _____

HERNIA: Yes No If so, where? _____ Is truss worn? _____

GASTROINTESTINAL: Ulceration or other disease? Yes _____ No _____

GENITO-URINARY: Scars _____ Urinal discharge _____

REFLEXES: Rhomberg _____

Pupillary _____ Light: Right _____ Left _____

Accommodation _____ Right _____ Left _____

KNEE JERKS: Right Normal _____ Increased _____ Absent _____

Left Normal _____ Increased _____ Absent _____

REMARKS: _____

EXTREMITIES: Upper _____ Lower _____ Spine _____

LABORATORY & OTHER SPECIAL FINDINGS: Urine Spec. Gr. _____ Alb. _____ Sugar _____

Other Laboratory Data (Serology, etc.) _____

Radiological Data _____ Electrocardiograph _____

GENERAL COMMENTS: _____

NAME OF EXAMINING DOCTOR (PLEASE PRINT)	SIGNATURE	
ADDRESS OF EXAMINING DOCTOR		
CITY	STATE	ZIP

MEDICAL EXAMINER'S CERTIFICATE (ONLY TO BE COMPLETED IF OPERATOR IS FOUND QUALIFIED)

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined

CRANE OPERATOR'S NAME

*with the knowledge of his/her duties,
I find him/her qualified under the regulations.*

Qualified only when wearing corrective lenses.

Qualified only when wearing a hearing aid.

Qualified—see Accommodation Statement attached.

A complete examination form for this person is on file in my office:

ADDRESS	
DATE OF EXAMINATION	NAME OF EXAMINING DOCTOR
SIGNATURE OF EXAMINING DOCTOR	
SIGNATURE OF OPERATOR	
ADDRESS OF OPERATOR	

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined

CRANE OPERATOR'S NAME

*with the knowledge of his/her duties,
I find him/her qualified under the regulations.*

Qualified only when wearing corrective lenses.

Qualified only when wearing a hearing aid.

Qualified—see Accommodation Statement attached.

A complete examination form for this person is on file in my office:

ADDRESS	
DATE OF EXAMINATION	NAME OF EXAMINING DOCTOR
SIGNATURE OF EXAMINING DOCTOR	
SIGNATURE OF OPERATOR	
ADDRESS OF OPERATOR	