Physical Examination Report

(To be completed by physician. Please type or print.)

Name of Applicant:____________________________________ DOB:_______________________

Male Female Height:__________________ Weight:________________

Remarks:____

Hearing______________________________ :Hearing aid necessary? L R None

Vision: Right _________ Left _________ With correction: Right ________ Left __________

Dental: Teeth:_____________________ Date of last dental exam: ___________________________

Urinalysis:____

DT Booster (within 5 years) Date given:_____________________________

Tuberculin Skin Test (within 6 months of date of this exam):

Circle One: Tine test, PPD, Mantoux, Other ____

Date given________ Date read ________ Results ________ X-ray needed? Y N Results________

Circle any abnormalities: Eyes L R Ears L R Nose Throat Sinuses Chest

Breast L R Lung L R Heart Thyroid Spine Abdomen Lymph Nodes Reflexes

Explanatory Remarks:____

Allergies:____

Medications (including OTC):____

Dietary Restrictions:____

Significant past medical issues/surgeries/dates

Medical History: (Please indicate if this applicant has had any of the following conditions and indicate date.)

High blood pressure	Heart disease
High cholesterol	Circulatory problems
Asthma, emphysema, bronchitis	Kidney stones/cysts/failure
Gall bladder issues	Hepatitis or liver problems
Depression/anxiety	Thyroid disease
Epilepsy/seizures	Cancer (specify:__________________)
Arthritis/Gout	Migraine headaches
Anemia/Blood disease	Diabetes (under control Y N ?)
Osteoporosis	Tuberculosis
Eating Disorder (specify__________)	HIV/AIDS (under control Y N ?)
Skin Disorder (specify___________)	Sleep disorder (specify______________)
Other:______________________	(Do you use a CPAP machine? Y N ?)

Current medical problems/diagnoses:____

____

History of addiction: (circle any): Tobacco Drugs Alcohol Other:_________________

Current treatment for addiction:____

Counseling/Therapy: (Please indicate any past or current therapies and results.)

____

Psychiatric History: (Please indicate any past or current psychiatric treatment and results.)

____

Are there any reasons why this person could not participate in the work of the Poor Handmaids of Jesus Christ Volunteer program or would there need to be any modifications in his/her activities?

____

Are you this person's regular physician? Y N If so, for how long?____________________

Signature:____

(Please use name stamp or include RX with your signature.)

Address:____

____

City_______________________________________State______________Zip Code______________

Telephone: _______________________________________

E-mail:____

Please mail or fax to:

Sr. Connie Bach, PHJC

PHJC Volunteer Program

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