



Occupational
Medicine
Services

Bethesda Care Arrow Springs
Phone: 513-282-7075
Fax: 513-282-7076

Bethesda Care Butler County
Phone: 513-874-3990
Fax: 513-860-5071

Bethesda Care Eastgate
Phone: 513-752-3695
Fax: 513-752-3039

Bethesda Care Norwood
Phone: 513-731-3399
Fax: 513-731-2882

Bethesda Care Queensgate
Phone: 513-241-4135
Fax: 513-241-6510

Bethesda Care Sharonville
Phone: 513-563-1505
Fax: 513-769-4776

Good Samaritan
Phone: 513-862-2875
Fax: 513-862-2860

PERIODIC MEDICAL HISTORY PHYSICAL EXAMINATION

Date: _____

Name (last, first, middle)	Social Security # / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	Age
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Are you seeing a physician on a regular basis at the present time? Yes No

If yes, explain briefly: _____

List all current medications: _____

Since your last exam have you had:

Yes No Changes in your health including changes in medication for current health problems?

Yes No Hospitalization?

Yes No Surgeries or other procedures?

Yes No Health problems related to your work exposures?

Yes No Any changes in job title/job duties?

Do you now or did you ever drink alcohol? Yes No Check type: Liquor Beer Wine
Amount per day/week/month: _____ Last alcohol: _____ Quit (date): _____

Do you now or did you ever smoke: Yes No Check type: Cigarettes Cigars Pipe
Amount per day: _____ Number of years smoked: _____ Quit (date): _____

Do you exercise on a regular basis: Yes No If yes, describe: _____

I certify that the above answers are true and complete and are aware that any material and deliberate falsification of fact on the above may be grounds for discharge.

Patient Signature: _____ Date: _____

Examiner Comments: _____

Physical Examination

(To be completed by the examiner)

Ht: _____ Wt: _____ BP: _____ Pulse: _____
 Repeat BP: _____ Exercise Pulse: _____

Without glasses:	Both: _____	Far Lt: _____	Far Rt: _____
	Both: _____	Near Lt: _____	Near Rt: _____
With glasses or contacts:	Both: _____	Far Lt: _____	Far Rt: _____
	Both: _____	Near Lt: _____	Near Rt: _____
Color vision:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Test Type:	<input type="checkbox"/> Lantern <input type="checkbox"/> Ishihara <input type="checkbox"/> Titmus		
Peripheral vision	Rt: _____ Lt: _____		
Audio	500 _____ 1000 _____ 2000 _____		
Rt / Lt			

URINE MULTISTIX		
Test	Normal Range	Results
Glucose	<i>Negative</i>	
Bilirubin	<i>Negative</i>	
Ketone	<i>Negative</i>	
Specific Gravity	<i>1.001 - 1.035</i>	
Blood	<i>Negative</i>	
pH	<i>5-9</i>	
Protein	<i>Negative - Trace</i>	
Urobilinogen	<i>0.2 – 1.0 mg/dL</i>	
Nitrites	<i>Negative</i>	
Leukocytes	<i>Negative</i>	

	NORMAL	ABNORMAL	COMMENTS
General Appearance			
Skin			
HEENT			
Neck			
Lungs			
Heart			
Vascular			
Abdomen			
Inguinal/genitalia			
Extremities			
Spine			
Curvature			
Range of Motion			
Straight Leg Raising			
Gait			
Neurological			
Psychological			

- Normal
- Abnormal findings: _____
- _____
- Medical restrictions: _____
- _____

Examiner Signature: _____ Date: _____