Gretna Clinic
107 Wall Blvd.
Gretna, LA 70056
504-433-5070

GENERAL PHYSICAL FORM

West Jefferson Industrial Medicine, L.L.C.

Marrero Clinic
4475 Westbank Expy.
Marrero, LA 70072
504-347-8471

Date_____ 20____

Company_____ Position_____

Applicant's Name _____ Phone (____)_____

Social Security No. _____ Date of Birth ____/____/____

Address _____
(Street of P.O. Box) (City) (State) (Zip Code)

Applicant's Medical History (to be completed by Applicant)
CIRCLE "Y" for YES or "N" for NO. IF YES, PLEASE EXPLAIN BELOW.

Y N Epilepsy/Seizures	Y N Earaches	Y N Gout	Y N Back Injury (lower)
Y N Dizziness	Y N Ruptured Eardrums	Y N Arthritis	Y N Arm Injury
Y N Headaches	Y N Chest Pains	Y N Varicose Veins	Y N Hand Injury
Y N Fainting Spells	Y N Heart Trouble	Y N Rectal Bleeding	Y N Knee Injury
Y N Psychiatric Illness	Y N High Blood Pressure	Y N Cancer or Tumor	Y N Leg Injury
Y N Depression	Y N Diabetes	Y N Frequent Backaches	Y N Foot/Ankle Injury
Y N Shortness of Breath	Y N Kidney Trouble	Y N Head Injury	Y N Hernia
Y N Asthma	Y N Difficulty Urinating	Y N Eye Injury	Y N Other (Detail)
Y N Tuberculosis	Y N Skin Disorders	Y N Neck Injury	_____
Y N Chronic cough	Y N Malaria	Y N Back Injury (upper)	_____

If your answer is YES to any of the above, please explain.

_____

_____

_____

Are you currently taking medication? YES or NO

If YES, please list each medication.

_____

Please list any operations you have had?

1_____ Approximate Date? _____

2. _____ Approximate Date? _____

Personal Doctor's Name_____ Address _____
(City) (State)

I certify that the foregoing statements are true to the best of my knowledge and belief. I understand that leaving out or misrepresenting facts called for above may be the cause for refusal of employment or separation from the company. I hereby grant permission to the examining physician to disclose any and all information herein or hereafter furnished by me to the Company as may be deemed necessary.

_____
Signature of Applicant

8/10

Name_____ Date _____

1. General Appearance and Personal Hygiene	2. Height	3.Weight	4. Temperature (oral)
5. Blood Pressure	6. Pulse	7. Gall	

8. Vision Indicate any eye diseases and date of same_____ Vision without glasses Distant (Snellen) R.20/ L.20/ Near (Jaeger type) R. % L. %	Color Vision Red Blue Green ____ ____ ____	Oculomotor Pupils:_____ Fund:_____ Reaction of pupils to light: _____ Accommodation:_____
Vision with glasses R.20/ L.20/ R. % L. %	Visual Field Restricted to: R.____% L.____%	Depth Perception ☐ WNL ☐ ABN.

9. Deformities	☐ NO ☐ YES	17. Lungs	☐ WNL ☐ ABN.	25. Tremor	☐ NO ☐ YES
10. Skin	☐ WNL ☐ ABN.	18. Heart	☐ WNL ☐ ABN.	26. Extremities	☐ WNL ☐ ABN.
11. Eyes	☐ WNL ☐ ABN.	19. Abdomen	☐ WNL ☐ ABN.	27. Varicosities	☐ NO ☐ YES
12. Ears	☐ WNL ☐ ABN.	20. Hernia	☐ NO ☐ YES	28. Back	☐ WNL ☐ ABN.
13. Nose	☐ WNL ☐ ABN.	21. Genitalia	☐ WNL ☐ ABN.	29. Enlarged Nodes	☐ NO ☐ YES
14. Mouth & Throat	☐ WNL ☐ ABN.	22. Varicocele	☐ NO ☐ YES	30. Rectal Exam (Optional)	☐ WNL ☐ ABN.
15. Head, Neck	☐ WNL ☐ ABN.	23. Hydrocele	☐ NO ☐ YES	31. Nervous & Mental Status	☐ WNL ☐ ABN.
16. Chest	☐ WNL ☐ ABN.	24. Reflexes	☐ WNL ☐ ABN.	32. EKG	☐ WNL ☐ ABN.

REMARKS:

LABORATORY

Urine SP. GR. Albumin Sugar Microscopic	Chemistry ☐ see attached
Audiogram ☐ Normal ☐ Abnormal	CBC ☐ see attached
Chest X-Ray ☐ Normal ☐ Abnormal	Pulmonary Function ☐ Normal ☐ Abnormal (see report)
Spine X-Ray ☐ Normal ☐ Abnormal	

A. Employment Without Restriction
B. Employment With Recommendations
C. Unclassified Pending Further Evaluation
D. Rejection Until Defect is Corrected
E. Rejection
F. Please Call For Discussion

CLEARED FOR RESPIRATOR USE YES ☐ NO ☐
MUST WEAR GLASSES OR CONTACTS YES ☐ NO ☐

Medical Examiner _____