Gretna Clinic	**General Physical Form**	Marrero Clinic
107 Wall Blvd.	West Jefferson Industrial Medicine	4475 Westbank Expy.
Gretna, LA 70056		Marrero, LA 70072
504-433-5070		504-347-8471

Date______________________________

Company____Position____

Applicant's Name____Phone___________________________

Social Security No.____ Date of Birth ____________________

Address____

(Street or P.O. Box) (City) (State) (Zip Code)

Applicant's Medical History (to be completed by Applicant)
Mark Yes or No. IF YES, PLEASE EXPLAIN BELOW.

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

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

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Are you currently taking medication?

If YES, please list each medication.

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Please list any operations you have had?

1.____Approximate Date?_______________

2.____Approximate Date?_______________

Personal Doctor's Name_______________________________________Address_______________________________________

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.

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Patient Signature