WINNING WHEELS
EMPLOYEE PHYSICAL EXAMINATION

Last Name: ______________________ First Name: ____________ Physician: ___________Date:____

Age: _____ Wt.:_____ Ht.: _____ BP: _____ Temp.: _____ Pulse: _____ Resp.: _____

Person Free of Communicable Disease? ☐Yes ☐No If no, please explain_______________________

MEDICAL HISTORY:

Hepatitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

If yes is answered to any of the above conditions, please explain ____________________________________

PHYSICAL EXAMINATION

General Appearance: (Including skin) ____

History of Any Major Medical Conditions ☐Yes ☐No If Yes, Explain ___________________________

History of Mental Illness ☐Yes ☐No If Yes, Explain ____

History of Any Major Surgeries ☐Yes ☐No If Yes, Explain ___________________________________

Head (Eye, Ear, Nose, Throat, Teeth) ____

History of Head Aches? ☐Yes ☐No If Yes, Explain ____

Neck ____

History of Neck Pain? ☐Yes ☐No If Yes, Explain ____

Back and Spine (Including Test for Flexibility) ____

History of Back or Spine Problems? ☐Yes ☐No If Yes, Explain ______________________________

Chronic Back Pain? ☐Yes ☐No If Yes, Explain ____

Lungs/Chest ____

Persistent Cough? ☐Yes ☐No If Yes, Explain ____

Past Chest X-Ray? __________ Date Reason _______________________________________

Abdomen ____

History of Hernia(s)? ☐Yes ☐No If Yes, Explain ____

History of Abdominal Pain? ☐Yes ☐No If Yes, Explain _____________________________________

History of Heart Trouble? ☐Yes ☐No If Yes, Explain ______________________________________

Musculoskeletal ____

Feet ____

History of Any Joint Pain (Wrist, Ankle, Knee)? ☐Yes ☐No If Yes, Explain ______________________

PHYSICIAN SIGNATURE ___________________________________DATE __________________

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Results of Drug Screening: ____________________ Date:_______________ Signature________________

WINNING WHEELS
EMPLOYEE MEDICAL HISTORY

*Please complete and bring with you to your employee physical examination

Name ______________________________ Age _____ Date ______________

Marital Status __________ Birthplace ______________________ Birthdate ______________

Occupation ____

All Previous Occupations ______________________________________

List All States in Which You Have Lived ______________________________

Education: Years High School _____ Years College _____ Years Post Graduate _____

Date of Last Physical Examination ______________________

Please List All Symptoms Found at Most Recent Physical Exam:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Routine Check-Up, No Symptoms __________

Has Any Blood Relative Ever Had: (Please Circle All Answers)

Cancer	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Stroke	☐Yes	☐No
Diabetes	☐Yes	☐No	Epilepsy	☐Yes	☐No
Heart Trouble	☐Yes	☐No	Mental Illness	☐Yes	☐No
HIV	☐Yes	☐No			

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY (Please Circle All Answers)

ILLNESSES: Have you ever had:

Measles	☐Yes	☐No	Cancer	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Diabetes	☐Yes	☐No
German Measles	☐Yes	☐No	Hepatitis	☐Yes	☐No
Mumps	☐Yes	☐No	High/Low Blood Pressure	☐Yes	☐No
Chicken Pox	☐Yes	☐No	Nervous Breakdown	☐Yes	☐No
Pleurisy	☐Yes	☐No	Hay Fever	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Heart Disease	☐Yes	☐No
Arthritis/Rheumatism	☐Yes	☐No	Asthma	☐Yes	☐No
Any Bone/Joint Disease	☐Yes	☐No	Migraine	☐Yes	☐No
Neuritis or Neuralgia	☐Yes	☐No	Bursitis, Scatia or Lumbago	☐Yes	☐No
Epilepsy	☐Yes	☐No	Any Other Disease	☐Yes	☐No
Allergies	☐Yes	☐No	If so, to what? ______________		

INJURIES: Have you had any:

Broken or Cracked Bones	☐Yes	☐No	Dislocations	☐Yes	☐No
Sprains	☐Yes	☐No	Concussion or Head Injury	☐Yes	☐No
Lacerations	☐Yes	☐No	Ever Been Knocked Unconscious	☐Yes	☐No
Back Injury	☐Yes	☐No	Ever Have Persistent Back Pain	☐Yes	☐No

WEIGHT: Now __________ One Year Ago __________ Maximum__________ When __________

SURGERY: Have you ever had surgery? ☐Yes ☐No

Type ______________________ Year ____________
Type ______________________ Year ____________
Type ______________________ Year ____________
Type ______________________ Year ____________

CURRENT MEDICAL HISTORY

How often do you drink alcoholic beverages? ____________________

Do you smoke? ☐Yes ☐No How many per day? ____________________

Have you been hospitalized for any illness? ☐Yes ☐No

Have you ever been advised to have any surgical operation which has never been done? ☐Yes ☐No

Give details: ____________________

DO YOU HAVE OR HAVE YOU HAD WITH THE PAST YEAR:

Frequent or sever headaches	☐Yes	☐No	Fainting Spells	☐Yes	☐No
Dizziness on change of position	☐Yes	☐No	Unconscious Spells	☐Yes	☐No
Blurred vision	☐Yes	☐No	Double vision	☐Yes	☐No
Spots before eyes	☐Yes	☐No	Infected eyes	☐Yes	☐No
Pain behind eyes	☐Yes	☐No	Any change in person	☐Yes	☐No
Do you wear glasses	☐Yes	☐No	When were eyes last checked	______	
Earaches	☐Yes	☐No	Discharge from ears	☐Yes	☐No
Ringing in ears	☐Yes	☐No	Decrease in hearing	☐Yes	☐No
Recurrent nose bleeds	☐Yes	☐No	Recurrent head cold	☐Yes	☐No
Sinus trouble	☐Yes	☐No	Hay fever	☐Yes	☐No
Persistent hoarseness	☐Yes	☐No	Difficulty in swallowing	☐Yes	☐No
Enlarged glands	☐Yes	☐No	Recurrent sore throat	☐Yes	☐No
Chest pain	☐Yes	☐No	Agina Pectoris (chest pain)	☐Yes	☐No
Coughed up blood	☐Yes	☐No	Pain in arm(s)	☐Yes	☐No
Chronic or frequent cough	☐Yes	☐No	Palpitations or heart flutters	☐Yes	☐No
Wake at night short of breath	☐Yes	☐No	Leg cramps on walking or at night	☐Yes	☐No
Short of breath on:			Recurrent stomach pain	☐Yes	☐No
walking several blocks	☐Yes	☐No	Backaches	☐Yes	☐No
laying down	☐Yes	☐No	Swelling of joints	☐Yes	☐No
walking one flight of stairs	☐Yes	☐No	Tingling/weakness in hands/feet	☐Yes	☐No
Purple lips or fingers	☐Yes	☐No	Loss of/change in hands/feet	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	Enlarged veins in legs	☐Yes	☐No
Recurrent back pains	☐Yes	☐No	Joint pains	☐Yes	☐No
Redness or heat in any joint	☐Yes	☐No	Muscle spasms	☐Yes	☐No
Any menstrual problems	☐Yes	☐No			

X-RAYS: Have you ever had x-rays of:

Gall bladder	☐Yes	☐No
Back	☐Yes	☐No
Stomach or colon	☐Yes	☐No
Extremities (arms or legs)	☐Yes	☐No
EKG	☐Yes	☐No
Electrocardiogram	☐Yes	☐No

IMMUNIZATIONS: Have you had:

Hepatitis B	☐Yes	☐No	Date ________
MMR	☐Yes	☐No	Date ________
Tetanus	☐Yes	☐No	Date ________

Have you ever taken insulin or tablets for diabetes? ☐Yes ☐No

I certify that the information given is accurate to the best of my knowledge.

Signature ____________________ Date ____________