North Central Health Care
Person centered. Outcome focused.

New Employee Physical Exam

Name: _____Date of Birth: _____

Medical & Surgical History (Please check any of the following problems that you have had in the past)

Ankles	Gallbladder	Hepatitis	Mental Illness/Depression
Arthritis	Gastrointestinal	Hips	Neurological Disorders
Asthma/Lung Disease	Genital/Urinary Condition	Intestinal Disease	Seizure
Blood Disorders	Gout Stones	Kidney Disease	Skin Disease Condition
Cancer	Head/Neck	Knees/Legs	Substance Abuse
Cardiovascular Condition	Hearing	Liver Disease	Vision (not glasses)
Diabetes	Heart Murmur	Lower/Middle Back	Wrist/Hands
Elbow/Shoulder	Hematological Conditions		

Please describe any "checked" answers: _____

_____

Additional problem(s) not listed: _____

_____

List any surgeries or hospitalizations that you have had and the year: _____

_____

Allergies (Please list any medication or food allergies that you may have)

_____

_____

Restrictions & Need for Accommodations: (Please check any of the following that you have had in the past)

Physical or mental limitations that requires accommodations in order to allow you to perform your job

Work Restrictions, temporary or permanent, related to a medical condition, surgery, or illness

Lifting limitations

Work-related injury, illness, or exposure

Please describe any "checked" answers: _____

_____

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I hereby certify that the information contained in this Health Questionnaire for Employment is true and correct and any misrepresentation of facts will be a basis for immediate dismissal.

I also authorize North Central Health Care (NCHC) Employee Health Services to exchange my employment health information with my health care provider(s), NCHC Worker's Compensation and Short Term Disability Insurance carriers, or my NCHC Supervisor(s) / Employer, for purposes of: continuity of health care, evaluation and treatment of work related injury / illness, evaluation of Americans with Disabilities (ADA) accommodation medical information, response to employee request for Family Medical Leave (FMLA), DOT drug testing and driver qualifications conducted by a covered provider, employer drug testing program, fitness for duty exams, evaluation relating to medical surveillance in the workplace, and in order to comply with NCHC's obligations to OSHA requirements. This authorization applies throughout the course of my employment at North Central Health Care.

I understand that NCHC Employee Health Records are controlled and maintained by Employee Health personnel and that only the minimum necessary health information with be exchanged, in order to accomplish the specific purpose.

Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Any evidence of communicable disease at the time of exam? Y N

If "Yes", describe:

_____

Physician Signature: _____Date: _____