



## **NORTH OAKS HEALTH SYSTEM PRE-PLACEMENT PHYSICALS**

Applicants are required to complete the following areas of the enclosed physical form. Failure to complete any required part of the physical form may result in a delay in completing the physical process.

### **Page 2 (Entire page must be completed.)**

1. Complete all demographic information
2. Read and initial each statement
3. Sign and Date

### **Page 3 (Entire page must be completed.)**

1. Name (print) and Social Security number
2. Review of Symptoms  
(Each item must be checked "Y" or "N". If "YES" then provide a comment in the "Comments" section.)
3. Family History
4. Sign and Date

### **Page 4 (Entire page must be completed.)**

1. Name (print) and Social Security number
2. Questions 3 – 6
3. Occupational History  
(Please check all that apply. Each "Y" or "N" question must be answered.)
4. Sign and Date

### **Page 5 (Entire page must be completed.)**

1. Name (print) and Social Security number
2. Occupational History  
(Please check all that apply. Each "Y" or "N" question must be answered.)
3. Sign and Date

### **Page 6 (Entire page must be completed.)**

1. Name (print) and Social Security number
2. Questions 1 – 6  
(Accuracy is extremely important. Please detail all information as requested.)
3. Sign and Date

### **Page 7**

1. Name and Social Security number



<b>EMPLOYEE PHYSICAL</b>						
Name (Last, First)					Date: ___/___/___	
Home Address						
City		State		Zip		Home Phone (    )
Cell Phone (    )						
SS#	Date of Birth ___/___/___	Age	Sex	Race		Marital Status S M W D Sep
Name of Primary Care Physician			Department Applying For			Job Position Applying For

**Please read and initial each statement.** Sign below as acknowledgment of information provided.

\_\_\_\_\_ I understand that my employment with North Oaks Health System is contingent upon successful completion of this pre-placement assessment. I understand that Employee Wellness will give me 10 working days to provide a medical clearance and/or medical records for any physical or mental condition that may affect my ability to perform the essential functions of this job with or without reasonable accommodation. I understand that if I fail to appear for my scheduled physical, rehab evaluation or drug screen, the job offer may be withdrawn.

\_\_\_\_\_ I understand that any falsification of the workers' compensation portion of this pre-placement assessment may be grounds for immediate termination.

\_\_\_\_\_ I understand that, if I am at risk for occupational exposure to bloodborne pathogens, I will be required to receive the Hepatitis B vaccine or to provide proof of vaccination or immunity.

\_\_\_\_\_ I agree to comply with North Oaks Health System's mandatory vaccination policies. I will provide proof of immunity to Measles, Mumps, Rubella and Varicella or if lab test shows no immunity, Employee Wellness will provide these vaccines to me at no charge.

\_\_\_\_\_ I agree to comply with all prescribed treatment (i.e., medications, therapy) by my health care providers in which noncompliance may affect my ability to safely perform my job duties and/or would be a safety risk to myself, co-workers, patients or others.

\_\_\_\_\_ I understand that if my urine drug screen results are positive, as determined by a certified Medical Review Officer, I will be denied employment and cannot reapply for at least one year.

I have read the above statements and agree to comply with all requirements in this pre-placement assessment. I certify that the information I provide on this pre-placement assessment is accurate to the best of my knowledge. I understand that any misstatement, misrepresentation, omission or falsification of any portion of this pre-placement assessment is grounds for immediate termination or refusal to hire.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

**FOR OFFICE USE ONLY**

COMMENTS: \_\_\_\_\_

REFERRAL

X-RAY: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

FOLLOW-UP: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

OTHER: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_





Name (print): \_\_\_\_\_ Social Security #: \_\_\_\_\_

**3. Do you use any prosthesis, colostomy appliances, artificial limbs, braces, assistive devices (glasses, hearing aids)?**

No  Yes If "Yes", please explain. \_\_\_\_\_

**4. Do you have any hobbies?**

No  Yes If "Yes", please explain hobbies, substances used (glue, paint, chemicals, etc.) and physical exposure (noise, temperature extremes, etc.). \_\_\_\_\_

**5. Please list medications, prescribed or over the counter, and health food supplements.**

\_\_\_\_\_  
 \_\_\_\_\_

**6. Allergy/Immune Status**

Please check if you have allergies to the following:

	NO	YES
Medications	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>
Powder	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

List any medication allergies: \_\_\_\_\_

List any food allergies: \_\_\_\_\_

List any other allergies: \_\_\_\_\_

Do you have a history of:

NO	YES	UNKNOWN	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body Piercing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an accidental needle stick and/or blood and body fluid exposure in the past? If "Yes", please give the date: ____/____/____

Last Blood Donation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**7. Emergency Contact Information:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Number: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Number: \_\_\_\_\_

Childhood Diseases (Please check if you have had):

- Red Measles
- Mumps
- Rubella
- Chickenpox
- Polio

TB Skin Test:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Result: \_\_\_\_\_

**OCCUPATIONAL HISTORY**

**8. Work History** – In chronological order, list each job, including military service.

FROM	TO	POSITION/JOB DUTIES	COMPANY
____/____/____	____/____/____	_____	_____
____/____/____	____/____/____	_____	_____
____/____/____	____/____/____	_____	_____
____/____/____	____/____/____	_____	_____

**Applicant/Employee:** I certify that the above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR OFFICE USE ONLY**

Reviewed by: \_\_\_\_\_  
 Signature Print Name & Title Date

Name (print): \_\_\_\_\_

Social Security #: \_\_\_\_\_

## OCCUPATIONAL HISTORY

**9. Please check all that apply:** Check "Y" for Yes or "N" for No

A. Have you ever worked in or around the following:																																								
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B. Have you ever used or been exposed to the following chemicals or conditions:																																																																												
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C. Do you have (or have you ever had) any hobbies/recreational activities that include:									
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Y	N								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								
<input type="checkbox"/>	<input type="checkbox"/>								

D. Have you recently used personal protective equipment on your prior jobs?													
<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; width: 50%;">Y</th> <th style="text-align: left; width: 50%;">N</th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	Y	N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Other: (list below)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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**E. Have you ever received medical surveillance (periodic check-ups or tests) as part of a prior job?**  
 No     Yes    If "Yes", please explain. \_\_\_\_\_

**F. Do you have any environmental allergies?**  
 No     Yes    If "Yes", please explain. \_\_\_\_\_

**G. Do you have any history of insect or tick bites?**  
 No     Yes    If "Yes", please explain. \_\_\_\_\_

**Applicant/Employee:** I certify that the above information is true and correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>FOR OFFICE USE ONLY</b>		
<p><b>Reviewed by:</b> _____</p> <p style="text-align: center; font-size: small;">Signature</p>	<p>_____</p> <p style="text-align: center; font-size: small;">Print Name &amp; Title</p>	<p>_____</p> <p style="text-align: center; font-size: small;">Date</p>



Name (print): \_\_\_\_\_

Social Security #: \_\_\_\_\_

**EMPLOYEE PHYSICAL**

- 1. Has a physician ever restricted your activities?  No  Yes  
If "Yes", please list the medical condition, what type of restrictions were placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.  
\_\_\_\_\_  
\_\_\_\_\_
- 2. Are you currently under any medical treatment by a physician, psychiatrist, psychologist or other physician?  No  Yes  
If "Yes", please list the medical condition being treated and your treating physician's name.  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Date of last Physical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_
- 4. Have you ever had surgery on any part of your body?  No  Yes  
If "Yes", please list the type of operation and your physician's name.  
\_\_\_\_\_  
\_\_\_\_\_
- 5. Have you ever received treatment for your back, neck, knee or other body part from a physician, chiropractor or therapist?  
 No  Yes  
If "Yes", please list the name of the physicians, chiropractors or therapists who performed the treatment.  
\_\_\_\_\_  
\_\_\_\_\_
- 6. Have you ever had an injury which required you to miss work?  No  Yes  
If "Yes", please list the type of injury, the amount of time missed from work, whether the condition fully healed or if it left you with any impairment, and whether you returned to work.  
\_\_\_\_\_  
\_\_\_\_\_

**WARNING:** Failure to truthfully answer inquiries about previous medical conditions may result in my forfeiture of Workers' Compensation benefits under R.S. 23:1208.1.

I have read and fully understand the above.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FOR OFFICE USE ONLY**

Reviewed by: \_\_\_\_\_  
Signature \_\_\_\_\_ Print Name & Title \_\_\_\_\_ Date \_\_\_\_\_

Name (print): \_\_\_\_\_

Social Security #: \_\_\_\_\_

**FOR OFFICE USE ONLY**

**PHYSICAL EXAMINATION**

Complaints: \_\_\_\_\_

PMH: \_\_\_\_\_ PSH: \_\_\_\_\_ OB/GYN: \_\_\_\_\_

**Physical Examination**

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Resp.: \_\_\_\_\_ Temp: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

**Ancillary Tests (select according to exam)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

<b>Vision</b>	<input type="checkbox"/> Uncorrected	<input type="checkbox"/> Corrected	
	Right	Left	Both
Near	20/	20/	20/
Far	20/	20/	20/

Ishihara's Test \_\_\_\_\_ / 14 correct  
 Visual Fields Right \_\_\_\_\_ Left \_\_\_\_\_

Does patient wear eyeglasses?  Yes  No  
 Does patient wear contact lenses?  Yes  No  
 Is patient wearing glasses/contacts?  Yes  No

**Other Tests:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Check if Normal/ Circle if Abnormal**

**1. Head/Neck**  
 \_\_\_ Head/Neck \_\_\_ Hearing  
 \_\_\_ Ear \_\_\_ Eye \_\_\_ Nose \_\_\_ Throat \_\_\_ Oral Cavity

**2. Heart/Lungs**  
 \_\_\_ Peripheral pulse  
 \_\_\_ Heart sounds \_\_\_ Lungs

**3. Gastrointestinal**  
 \_\_\_ Abdomen

**4. Genitourinary**  
 \_\_\_ Genitals \_\_\_ Pelvis(female)/N.I. \_\_\_ Prostate/N.I.

**5. Skin & Soft Tissue**  
 \_\_\_ Lymph nodes \_\_\_ Breasts (male/female)/N.I.  
 \_\_\_ Skin (attach drawing of burns, scars, etc)

**6. Musculoskeletal**  
 \_\_\_ Limbs/joints \_\_\_ Spine/Back

**7. Neurological**  
 \_\_\_ Mental Status  
 \_\_\_ Balance \_\_\_ Gait \_\_\_ Coordination  
 \_\_\_ Reflexes

Comments: \_\_\_\_\_

\_\_\_\_\_

**Employee/Applicant medically qualified to wear:**

Respirator:  Yes  No  NA

Based on information obtained from the history of this patient, this individual IS / IS NOT free of communicable disease at this time.

**Based on findings of this physical examination: Employee/Applicant IS / IS NOT physically qualified (pending results of any outstanding ancillary tests) for employment at: \_\_\_\_\_.**

Impression: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_