Griffin Health Services Corporation

Griffin Hospital

Employee Health Service
Medical Record

NAME: DATE: / /

ADDRESS:

TELEPHONE: BIRTHDATE / / SOCIAL SECURITY #

DATE OF LAST PHYSICAL / / FAMILY DOCTOR: ADDRESS:

FAMILY HISTORY: HEART DISEASE CANCER DIABETES STROKE

DOMINANT HAND: LEFT RIGHT

LIST ANY HOSPITALIZATIONS OR SURGERY YOU HAVE HAD IN THE PAST

DATE	REASON

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES NO IF YES, WHAT ARE THEY?

DO YOU SMOKE CIGARETTES? YES____ NO____ If yes # of packs per day _____.

ARE YOU USING HARMFUL DRUGS? YES____ NO____

HOW MUCH ALCOHOL DO YOU DRINK? None____ 1-7 drinks per week____ 8-14 drinks per week____ 15+ drinks per week____

LIST ANY CHRONIC HEALTH PROBLEMS YOU MAY HAVE.

ALLERGIC REACTIONS: HAVE YOU EVER EXPERIENCED ADVERSE REACTIONS TO ANY DRUG, FOOD OR CHEMICAL?
IF SO, PLEASE DESCRIBE REACTION:

PLEASE CHECK IF YOU HAVE EVER:

	BEEN, OR NOW INVOLVED IN LITIGATION FOR PERSONAL INJURY		COLLECTED PENSION FOR DISABILITY
	BEEN DISCHARGED FROM THE MILITARY FOR HEALTH REASONS		WORKED WITH RADIOACTIVE SUBSTANCES
	BEEN REJECTED FROM THE MILITARY FOR HEALTH REASONS		BEEN IN THE MILITARY SERVICE
	BEEN REFUSED EMPLOYMENT FOR HEALTH REASONS		BRANCH OF SERVICE: / HOW LONG?
	BEEN FORCED TO GIVE UP A JOB FOR HEALTH REASONS		
	MOVED FROM YOUR HOME BECAUSE OF HEALTH RISKS		ASSIGNMENT:
	BEEN MADE ILL BY YOUR WORK		
	RECEIVED WORKERS' COMPENSATION OR FILED A CLAIM		
	BEEN REFUSED LIFE INSURANCE		
	HOW MANY DAYS OF WORK DID YOU MISS IN THE PAST 12 MONTHS DUE TO ILLNESS OR INJURY?		

JOB APPLIED FOR:

PLEASE CHECK IF YOU HAVE OR HAVE HAD IN THE PAST:							
1	WEIGHT LOSS>10LBS. W/O DIET	28	BREAST LUMPS	53	HEMORRHOIDS	80	HEAD INJURY/CONCUSSION
2	RECENT WEIGHT GAIN OF>10 LBS.	29	BREAST SURGERY	54	FREQUENT DIARRHEA	81	LOSS OF CONSCIOUSNESS
3	PERSISTENT FATIGUE	30	FREQUENT COUGH	55	HEPATITIS OR JAUNDICE (YELLOW SKIN)	82	MEMORY LOSS
4	REPEATED INFECTION	31	BRONCHITIS	56	HERNIA	83	SLEEP DISTURBANCE
5	NIGHT SWEATS	32	EMPHYSEMA	57	KIDNEY INFECTION/BLADDER INFECTION	84	NERVOUSNESS
6	SKIN RASH	33	ASTHMA OR WHEEZING	58	KIDNEY STONES	85	MENTAL ILLNESS
7	GLAUCOMA/CATARACTS	34	PNEUMONIA	59	PAINFUL URINATION	86	FEAR OF HEIGHTS
8	FREQUENT/SEVERE HEADACHE	35	COUGHED UP BLOOD	60	BLOODY URINE	87	DIABETES
9	SINUS PAIN	36	HIGH BLOOD PRESSURE	61	URINATING FREQUENTLY AT NIGHT	88	THYROID PROBLEMS OR GOITER
10	WEAR GLASSES OR CONTACTS	37	SHORTNESS OF BREATH WHEN:	62	DISCHARGE FROM PENIS	89	RHEUMATIC FEVER
11	BLURRED VISION OR DOUBLE VISION	A	WALKING ON LEVEL GROUND	63	ARTHRITIS	90	POLIO
12	EYES SENSITIVE TO LIGHT	B	WALKING UP ONE FLIGHT OF STAIRS	64	TENDONITIS/BURSITIS	91	TUBERCULOSIS
13	EAR PAIN OR DISCHARGE	38	NEED TO SLEEP ON TWO OR MORE PILLOWS	65	SWELLING/REDNESS/HEAT OF ANY JOINTS	92	VENEREAL DISEASE
14	EAR INFECTION	39	HEART ATTACK	66	FRACTURE	93	CANCER
15	EAR SURGERY	40	STROKE	67	DISLOCATION OF JOINT	94	MULTIPLE SCLEROSIS
16	DIZZINESS	41	CHEST PAIN/ANGINA	68	ARM PAIN	95	CARPAL TUNNEL SYNDROME
17	CHANGE IN HEARING	42	PALPITATION/HEART FLUTTER	69	ARM/LEG WEAKNESS	96	SILICOSIS
18	HEARING AID	43	HEART MURMUR	70	WEAKNESS/TINGLING OF THE FINGERS	97	ASBESTOSIS
19	FAINTING	44	CALF PAIN	71	HAND SURGERY	98	SEIZURES/CONVULSIONS
20	ANOREXIA	45	ANKLE SWELLING	72	KNEE INJURY/SURGERY	99	OTHER
21	BULIMIA	46	BLOOD CLOTS	73	FOOT PROBLEMS		
22	RECURRENT MOUTH SORES	47	CHANGE IN APPETITE	74	MUSCLE SPASMS		
23	BLEEDING GUMS	48	FREQUENT INDIGESTION OR STOMACH PAIN	75	BACK PAIN OR INJURY		FOR WOMEN:
24	DIFFICULTY SWALLOWING	49	VOMITED BLOOD	76	BACK SURGERY	100	PROBLEMS W/PERIODS
25	PERSISTANT HOARSENESS	50	CHANGE IN BOWEL HABITS	77	TREMORS	101	PREGNANCIES-NUMBER
26	NECK INJURY	51	BLOODY/BLACK BOWEL MOVEMENTS	78	ANEMIA	102	PROBLEMS W/PREGNANCIES
27	NECK RADIATION	52	FREQUENT CONSTIPATION	79	BLOOD TRANSFUSION	103	ARE YOU PREGNANT NOW?

Last Menstrual Period

Date ____/____/____

Communicable Disease History

Have you ever had

Scarlet Fever	Yes	No
Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Hepatitis	Yes	No

Immunization Record

Please List Date

Measles Vaccine ____/____/____

Rubella Vaccine ____/____/____

Hepatitis Vaccine ____/____/____

Flu Vaccine ____/____/____

Small Pox Vaccine ____/____/____

Tuberculin Test ____/____/____

Tetanus Toxoid ____/____/____

The Statements made on this form are true and complete.

Signature _____ Date

EXPLANATION OF POSITIVE ANSWERS (By Person Reviewing Form)

Signature of Person Reviewing Form _____

TEST REPORTS

P.P.D. Date Given _____/_____/_____ Site: Left Forearm_____ Right Forearm_____

By:_____ Results: Negative_____ Positive_____

EKG N/A_____ Negative_____ Positive_____

RUBELLA: Non Immune_____ Date Given _____/_____/_____ Site: Right Deltoid_____ Left Deltoid_____

Given by_____

MEASLES: Date Given _____/_____/_____: Site: Right Deltoid_____ Left Deltoid_____ Given by: _____

Lab Personnel Only: Color Blindness Test Negative_____ Positive_____

Dietary Personnel Only: Stool Specimen: Negative_____ Positive_____

Urine Culture and Sensitivity Date _____/_____/_____ Result _____

Drug Test: Negative_____ Positive_____

Back Evaluation: _____

Other Findings: _____

Physical Examination

Position _____

Height:_____ Weight:_____ BP:_____ T._____ P._____ R._____

	NORMAL	ABNORMAL	EXPLANATION
HEAD a. Eyes b. Ears			
NECK a. Thyroid b. Lymphatics			
CHEST			
HEART			
ABDOMEN a. Palpitation b. Any Hernias c. Genital			
EXTREMITIES (INCLUDE, RANGE FOR BACK, NECK & KNEES) a. Reflexes b. Blood Vessels c. Function			
BACK a. Movement b. Posture			
SCARS			

Are there any muscular skeletal problems that would effect the individual's physical capability to do any job? No____ Yes____

Explain _____

_____

WORK LIMITATIONS FOR CURRENT POSITION: EXPLAIN _____

_____

COMMENTS: _____

_____

_____

Recommended for hire_____ Yes ☐ _____ No ☐ Explain _____

_____

DATE:_____ SIGNATURE OF PHYSICIAN: _____

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