



1275 S. State Street, Dover, DE 19901
phone (302) 678-1303 fax (302)736-4332

800 N. DuPont Blvd, Milford, DE 19963
phone (302) 430-5705 fax (302)430-5679

632 Mulberry St, Milton, DE 19968
phone (302) 684-3812 fax (302) 684-2012

Patient Label

GENERIC PHYSICAL

Date: ___/___/___ Name: _____ Sex: M F
Street Address: _____
City: _____ State: _____ Zip: _____
Current Occupation: _____ Job Description: _____
Phone Number: (____) _____-_____ Family Physician: _____

Allergies (please list): _____

Current medications (include herbal remedies): _____

YOUR MEDICAL HISTORY:

Do you have now or ever had any of the following?	NO	YES	Do you have now or ever had any of the following?	NO	YES
Back injury and/or problem	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bedridden due to injury	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>
Been hospitalized (provide date(s): _____)	<input type="checkbox"/>	<input type="checkbox"/>	Major joint surgery	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stool or urine	<input type="checkbox"/>	<input type="checkbox"/>	Neck and/or back surgery	<input type="checkbox"/>	<input type="checkbox"/>
Broken bone	<input type="checkbox"/>	<input type="checkbox"/>	Received a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Current health concern	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>
Depression and/or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Smoke and/or smokeless tobacco use: provide # yrs _____	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness, lightheadedness, and/or fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema and/or chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Torn muscle and/or severe strain or sprain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent heartburn and/or stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	Toxic exposure (dust, fumes, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Gout, bursitis, or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Yellow jaundice and/or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Other medical condition: _____	<input type="checkbox"/>	<input type="checkbox"/>

Briefly explain "yes" answers: _____

I attest that the above is a true and full disclosure of my past medical history.

Patient Signature: _____ Date: ___/___/___ Time: _____

Provider's comments: (Comment on any positive answers above)

Provider's Signature: _____ Date: ___/___/___ Time: _____

Barcode





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Type of Exam:	General:
<input type="checkbox"/> Pre-employment	Weight: _____ kg
<input type="checkbox"/> Annual	Height: _____ in.
<input type="checkbox"/> Fit for duty	Pulse: _____
<input type="checkbox"/> School	Blood pressure: _____ / _____
<input type="checkbox"/> Other: _____	Temperature: _____

Audiogram:				
Right ear:	500: _____ db	1000: _____ db	2000: _____ db	4000: _____ db
Left ear:	500: _____ db	1000: _____ db	2000: _____ db	4000: _____ db

Color Vision				Visual Acuity (uncorrected)		
Right:	_____	Left:	_____	OD: _____	OS: _____	OU: _____
Peripheral Vision				Visual Acuity (corrected)		
Right:	_____	Left:	_____	OD: _____	OS: _____	OU: _____

Urinalysis												
Void	Turbid	Color	Leuk	Nitrate	Urobili	Prot	pH	Blood	Sp. Grav	Ketone	Bili	Gluc
CC	Clear											
Cath	Hazy											

Nurse/Tech Signature: _____ Date: ____/____/____ Time: _____ AM / PM

Nurse/Tech Comments:

Provider's Signature: _____ Date: ____/____/____ Time: _____ AM / PM

Barcode

