Mercyhealth
A passion for making lives better.

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Post-Offer Physical Exam/DOT Physical Exam

Date:_____

Employer:_____

Position:_____

Applicant's Name:_____

Address: _____

City:_____

State:_____ Zip Code:_____

Home Phone: _____Cell Phone: _____

Date of Birth:_____

Social Security Number:_____

PLEASE DO NOT WRITE BELOW THIS LINE – OFFICE USE ONLY

_____Able to perform job functions

_____Able to perform job functions with the following accommodations

_____Temporary _____Permanent

_____

_____

_____Pending:____

_____

_____

_____Unable to perform essential job functions

Physician signature **Date**

Company Notified: _____ **Initials:** _____

MERCY OCCUPATIONAL HEALTH SERVICES **DATE OF EXAM_____**
POST-OFFER EVALUATION FORM

The purpose of this post-offer evaluation is to determine your work capabilities for the company with which you applied. Other health information may be collected for use during possible medical emergencies. We encourage you to answer all questions. This is not intended to be a health evaluation for other purposes. Your personal physician should be consulted for any health problems and for routine medical exams.

Company name:_____ Sex: □ Male □ Female
Name:_____ Birthday: _____/_____/_____
Street Address:_____
City, State, Zip:_____
Home Number:_____Cell Phone:_____
Social Security Number:_____ Personal Physician:_____

Occupational History: Check if your previous work has involved exposure to any of the following:

Previous employers (list most recent first)	# of years @ Co.	Asbestos	Chemical Or Solvents	Fumes (Metal Weld)	Mist (Spray Paints Oil)	Mineral Dust	Other Dust	Blood Body Fluids	Noise	Other (Identify)

Have you ever worked with material you consider to be hazardous? □ Yes □ No
Have you ever become allergic to or treated for chemical exposure? □ Yes □ No
Have you ever been denied employment or insurance for health reasons? □ Yes □ No
Have you ever filed a Workers Compensation claim or received benefits as a result of a work injury or disease? □ Yes □ No
Have you ever had a n impairment or disability award? □ Yes □ No

Additional Information: Explain any "Yes" Answers:

_____

_____

Medical History:

Do you have any medical condition that is currently being treated by a doctor or chiropractor? □ Yes □ No
If so, please list or describe:

_____

Are you currently taking any medications? If so, please list: **(Include over-the-counter.)** □ Yes □ No

_____

_____

Do you have any allergies? If so, please list. □ Yes □ No

_____

Have you ever had surgery or been advised to have surgery? If so, please explain: □ Yes □ No

_____

Have you ever been in the hospital? (Exclude Childbirth) If so, please explain: □ Yes □ No

_____

Have you ever been immunized against Hepatitis B? □ Yes □ No
Have you ever been treated for alcohol or drug addiction? □ Yes □ No
Please explain, giving dates of treatment. □ Yes □ No

_____

Are you currently pregnant? If yes, what is your expected due date? _____ □ Yes □ No

Health Habits:

How much alcohol do you drink per week? (Beer, Wine, or Hard Liquor)

□ None □ 1-7 □ 8-14 □ over 14

Have you smoked cigarettes in the past? □ Yes □ No

If you smoke now, how many cigarettes per day?

□ Less than ½ pack □ ½ to 1 pack □ 1-2 packs □ over 2 packs

How many years have you smoked? _____

If you used to smoke, how many cigarettes per day did you smoke?

□ Less than ½ pack □ ½ to 1 pack □ 1-2 packs □ over 2 packs

How many years did you smoke? _____

Do you smoke pipes or cigars? □ Yes □ No

Do you use snuff or chewing tobacco? □ Yes □ No

Medical History – Have you had any of the following symptoms or conditions diagnosed by a doctor or chiropractor? Explain any yes answers in the space provided below:

Skin rash or hives □ Yes □ No _____

Sores that won't heal □ Yes □ No _____

Moles that have changed □ Yes □ No _____

Eczema □ Yes □ No _____

Skin Cancer □ Yes □ No _____

Hay Fever □ Yes □ No _____

Persistent cough □ Yes □ No _____

Bronchitis – recurrent or chronic □ Yes □ No _____

Emphysema □ Yes □ No _____

Recurrent wheezing □ Yes □ No _____

Asthma □ Yes □ No _____

Shortness of breath w/light exercise □ Yes □ No _____

Coughing up blood □ Yes □ No _____

Tuberculosis □ Yes □ No _____

Other Lung Disease □ Yes □ No _____

Persistent hoarseness □ Yes □ No _____

Heart Palpitations □ Yes □ No _____

Heart Rhythm Problems □ Yes □ No _____

Heart Murmur □ Yes □ No _____

Leg pain after walking short distance □ Yes □ No _____

Swelling of feet or ankles □ Yes □ No _____

Chest Pain/Ache □ Yes □ No _____

Heart Attack □ Yes □ No _____

Heart Surgery □ Yes □ No _____

Heart Failure □ Yes □ No _____

High Blood Pressure □ Yes □ No _____

Other Heart Disease □ Yes □ No _____

Varicose Veins □ Yes □ No _____

Blood Clot □ Yes □ No _____

Blood Clotting Disorder □ Yes □ No _____

Anemia □ Yes □ No _____

Other Blood Disorders □ Yes □ No _____

Difficulty w/Balance or coordination □ Yes □ No _____

Tremors □ Yes □ No _____

Difficulty with memory □ Yes □ No _____

Dizzy spells □ Yes □ No _____

Stroke □ Yes □ No _____

Blood in stools or black stools □ Yes □ No _____

Persistent abdominal pain □ Yes □ No _____

Stomach or Duodenal Ulcer	□ Yes □ No	
Colon Polyps	□ Yes □ No	
Hernia or Rupture	□ Yes □ No	
Liver Cirrhosis	□ Yes □ No	
Colitis	□ Yes □ No	
Other Colon, Liver, Stomach Disease	□ Yes □ No	
Kidney Failure or Insufficiency	□ Yes □ No	
Blood in urine	□ Yes □ No	
Kidney Stones	□ Yes □ No	
Bladder Polyps or Tumors	□ Yes □ No	
Epilepsy / Seizures	□ Yes □ No	
Multiple Sclerosis	□ Yes □ No	
Neuropathy	□ Yes □ No	
Numbness of arms or legs	□ Yes □ No	
Polio	□ Yes □ No	
Other Nervous System Diseases	□ Yes □ No	
Unintentional weight loss > 10 lbs.	□ Yes □ No	
Persistent swollen lymph nodes	□ Yes □ No	
Diabetes	□ Yes □ No	
Hepatitis	□ Yes □ No	
Thyroid Trouble	□ Yes □ No	
Gout	□ Yes □ No	
Cancer	□ Yes □ No	
Arthritis	□ Yes □ No	
Disc Condition (back or neck)	□ Yes □ No	
Surgery	□ Yes □ No	
Sciatica	□ Yes □ No	
Back / Neck pain or strain	□ Yes □ No	
"Pinched nerve"	□ Yes □ No	
Knee Strain or Cartilage Damage	□ Yes □ No	
Leg pain	□ Yes □ No	
Carpal Tunnel Syndrome	□ Yes □ No	
Tendonitis	□ Yes □ No	
Tennis Elbow or Epicondylitis	□ Yes □ No	
Shoulder Strain / Rotator Cuff Problem	□ Yes □ No	
Muscle Disease	□ Yes □ No	
Bone or Joint Disease	□ Yes □ No	
Other Muscle, Bone, or Joint Problem	□ Yes □ No	
Hearing Loss	□ Yes □ No	
Vision Loss (not corrected by glasses)	□ Yes □ No	
Color Blindness	□ Yes □ No	
Eye Disease	□ Yes □ No	
Chronic fatigue	□ Yes □ No	
Depression	□ Yes □ No	

The above information is an accurate account of my medical history.

Patient Signature **Date**

Physician or Nurse Comments

This medical history has been reviewed with this patient

Physician or Nurse Signature **Date**

INFORMATION REQUEST/AUTHORIZATION OF TREATMENT AND/OR TESTING

PATIENT NAME:_____DOB_____

COMPANY_____

I authorize Mercy Occupational Health Services/Urgent Care to perform al tests and/or procedures relative to my injury/illness or physical evaluation as deemed necessary by the attending physician/physician's assistant, my employer, or insurance carrier. I understand testing may include, but is not limited to, drug and alcohol screening.

I also request Mercy Occupational Health Services/Urgent Care to release and/or obtain information concerning my present injury, illness, or physical evaluation to my employer, employer's insurance carrier, all treating physicians, representing attorneys, the State Worker's Compensation Board, and any others as listed below.

Other:_____

_____

_____ _____

Patient Signature Date

Occupational Health Services/Urgent Care
Information Release/Consent for Treatme

Patient Sticker