EMPLOYEE HEALTH SERVICES
OCCUPATIONAL HEALTH SERVICES

Section 1: Applicant Information – To be completed by the Applicant and reviewed by Medical Practitioner

Last Name: _____ First Name: _____ Middle Name:_____

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____
(MM/DD/YYYY)

Mothers Maiden Name: _____ Last names you have used in the past _____

Home Address

Street Address: _____ Primary Phone Number : _____

City: _____ State: _____ Zip Code: _____

Alternate Phone Number: _____ E-mail Address: _____

Company: _____ Department: _____ Job Title: _____

Primary Care Provider/Doctor: _____ Phone Number: _____

Section II (a): Medical Conditions – To be completed by the Applicant and reviewed by the Medical Practitioner

1. Do you have any health impairment which is a potential risk to other employees or which might interfere with the performance of your duties, including the over use or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter your behavior? ☐ No ☐ Yes **If yes, explain:** _____
_____
_____

2. Are you currently under the care of a physician for any condition which would pose a direct threat to your own health or safety or to the health or safety of or co-workers? ☐ No ☐ Yes **If yes, explain**: _____
_____
_____

3. Have you ever been injured on the job which required medical treatment? ☐ No ☐ Yes **If yes, explain when**, employer, nature of injury, and any resulting restrictions. _____
_____
_____

4. Surgeries? ☐ No ☐ Yes **If yes, list surgery** and date of surgery below.

Surgery	Date

_____
Provider Initials

Section II (a): Medical Conditions – To be completed by the Applicant and reviewed by the Medical Practitioner (cont)

5. **Current Medication (include OTC/supplements)**

	Dose	Reason

6. **Allergies:** ☐ No ☐ Yes If yes, please list:
_____

7. Tobacco use ☐ No ☐ Yes If yes, how much? _____

8. Alcohol use: ☐ No ☐ Yes If yes, how many drinks per day? _____

9. **Family History (parents, grandparents, brothers, sisters)**

High blood pressure	☐ No	☐ Yes	_____
Heart disease	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Stroke	☐ No	☐ Yes	_____
Cancer	☐ No	☐ Yes	_____
Other	☐ No	☐ Yes	_____

Name_____ _____
Provider Initials

Section II (a): Medical Conditions – To be completed by the Applicant and reviewed by the Medical Practitioner (cont)

To the best of your knowledge, have you ever had, required treatment for, or do you presently have any of the following conditions?

☐ Yes ☐ No 1. Eye/vision problems except glasses
☐ Yes ☐ No 2 .Ear/nose/throat problems or other ENT problems/surgery
☐ Yes ☐ No 3. High or low blood pressure
☐ Yes ☐ No 4. Heart or vascular disease of any kind
☐ Yes ☐ No 5. Heart surgery and/or implanted devices (pacemaker, including defibrillator, etc.)
☐ Yes ☐ No 6. Lung disease of any type (asthma,bronchitis, emphysema)
☐ Yes ☐ No 7. Any blood disorder (anemia, hemophilia,blood clots, Polycythemia, etc.)
☐ Yes ☐ No 8. Diabetes, glucose intolerance, or sugar in urine
☐ Yes ☐ No 9. Thyroid problem
☐ Yes ☐ No 10.Stomach, liver, or intestinal disorder
☐ Yes ☐ No 11.Kidney problems/stones or blood in urine
☐ Yes ☐ No 12.Any other urinary or bladder problems not listed above
☐ Yes ☐ No 13.Skin disorder problem
☐ Yes ☐ No 14.Allergies or allergic reactions to any substance, medication or food
☐ Yes ☐ No 15.Infectious/contagious disease/Tb/HIV
☐ Yes ☐ No 16.Any sleep problems: obstructive sleep apnea, restless leg syndrome, narcolepsy, shift work sleep disorder, insomnia
☐ Yes ☐ No 17.Epilepsy, fits or seizures
☐ Yes ☐ No 18.Loss of consciousness, memory, or concussion
☐ Yes ☐ No 19.Frequent or severe headaches
☐ Yes ☐ No 20. Dizziness/fainting spells/balance problems
☐ Yes ☐ No 21. Frequent motion sickness requiring medication
☐ Yes ☐ No 22. Stroke or Transient Ischemic Attack (TIA), brain tumor or other brain disorder
☐ Yes ☐ No 23. Any neurologic disorder or nerve problems numbness and/or paralysis, not listed above
☐ Yes ☐ No 24. Attention deficit disorder with or without hyperactivity
☐ Yes ☐ No 25. Anxiety, depression, bipolar disorder, adjustment disorder, PTSD, or schizophrenia
☐ Yes ☐ No 26. Suicide attempt or thought (ideation) of suicide
☐ Yes ☐ No 27. Evaluation, treatment, or hospitalization for alcohol or substance use, abuse, addiction, or dependence (including illegal drugs, prescription medications or other substances)
☐ Yes ☐ No 28. Any other psychiatric disorder, mental health evaluation/hospitalization
☐ Yes ☐ No 29. Back pain, joint problems, or orthopedic surgery
☐ Yes ☐ No 30. Amputation, prosthesis, or use of ambulatory devices (cane, walker, braces, etc.)
☐ Yes ☐ No 31. Fractures, recurrent dislocations or limitation of motion of any joint
☐ Yes ☐ No 32. Any diseases, surgeries, cancers, illnesses or disabilities not listed on this form?
☐ Yes ☐ No 33. Any hospital admissions within the last six years Not listed elsewhere in this section?

I certify that the information given above is true to the best of my knowledge. I understand that any discovery of false or misleading information would be grounds for dismissal. Oswego Health applicants understand that the offer of employment received is contingent on successfully completing the physical examination. I further understand that ownership of this information belongs to Oswego Hospital and/or the company designated below.

I , _____, hereby give Oswego Hospital Occupational Health permission to release to
(Name)
_____the results of my physical exam and associated testing. I certify that the information provided
(Company Name)
above is true to the best of my knowledge. I further understand that ownership of this information belongs to the above named company, and that I

must contact them for any information regarding these results.

I give permission for Employee/Occupational Health to enter any immunizations that I receive through this office into the NYS Immunization Registry

_____ _____
Signature Date

Name_____ _____
Provider Initials

Section II(b): Medical Conditions – To be completed by the Medical Practitioner

Instructions: For each "YES" answer, identify the item numbers, the condition/diagnosis, date of onset or diagnosis, any treatment required or received, the current status of the condition, and any limitations due to the condition. As applicable, attach supporting documentation to verify findings. Additional sheets may be added as needed, being sure applicant name and date of birth appear on each additional sheet.

Number	Additional information (please print)

Name_____

_____
Provider Initials

REPORT OF MEDICAL EXAMINATION

Sections III and IV should be completed by the Medical Practitioner or other medical staff to the satisfaction of the Medical Practitioner.

Section III: Vision

ACUITY	UNCORRECTED FAR	CORRECTED - FAR	UNCORRECTED NEAR	CORRECTED NEAR	FIELD OF VISION
Right Eye	20/	20/			○ _____
Left Eye	20/	20/			○ _____
Both Eyes	20/	20/			

Ishihara Vision Testing Results:

☐ Passed ☐ Failed Number: _____ Can the Applicant distinguish red, green, and yellow? ☐ Yes ☐ No

Depth Perception Number: _____ (must perceive minimum of 5)

Section III: Hearing

Audiometer Threshold Value					
	500Hz	1,000Hz	2,000Hz	4,000Hz	
Right Ear (Unaided)					PASS FAIL
Left Ear (Unaided)					PASS FAIL
Right Ear (Aided)					PASS FAIL
Left Ear (Aided)					PASS FAIL

Section IV: Physical Examination – Items 1-12 of this section must be completed by the Medical Practitioner.

Height (inches only) _____in. Weight (lbs)_____lbs. Body Mass Index (BMI)_____

Pulse Resting: _____ Initial Blood Pressure _____ Repeat Blood Pressure _____

Temperature: _____ Respirations: _____

POC Urine:

PH:_____ SG:_____ BLD:_____ Sugar:_____ Protein:_____

Nurse Signature: **Date:**

Name_____ _____ Provider Initials

Oswego Health
Employee/Occupational Health

Check YES if the body system is normal. Check NO if there are any abnormalities. Discuss any NO answers in detail in the space provided

	Yes	No		Yes	No
1.General – Alert, oriented, appears stated age, NAD. Appearance, behavior, and speech are appropriate			7. HEENT – Normocephalic, PERRLA, EOM's intact. Conjunctivae clear, sclerae white. TMs pearly gray, landmarks intact, no perforations. Nares patent. Posterior oropharynx without erythema or exudate, oral mucosa moist without sores, lesions, or discolorations.		
2. NECK: Supple, trachea midline, thyroid without enlargement or palpable nodules, no carotid bruits, no lymphadenopathy			8. SKIN: Intact, warm and dry, no rashes noted		
3. LUNGS: clear to auscultation, no adventitious sounds			9. HEART: Apical pulse with RRR, S1, S2 present without murmurs		
4. ABDOMEN: Soft, non-distended, +bowel sounds, no CVA tenderness, no organomegaly or masses appreciated.			10. MUSCULO/SKELETAL: Full ROM of all major joints without noted deficits – age appropriate muscle tone and strength – spine straight – full flexion. Able to perform deep knee bend upon exam. No spinal tenderness upon palpation. Gait smooth .		
5. PERIPHERAL VASCULAR: No pedal edema, no calf tenderness or swelling, + 2 pp bilaterally.			11. NEURO: Cranial nerves II –XII grossly intact, DTR's +, no cerebellar, motor or sensory deficits on gross exam. Romberg neg		
6. PSYCH: Positive affect					

Additional Medical Comments

Item #	**Additional Information (Please Print)**

This individual, from the physical examination performed and history provided, appears free from any health impairment which might be a potential risk to other employees or which might interfere with the performance of the applicant's duties, including the over use or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior. This individual appears capable of performing all duties in his/her prospective job/position without restrictions.

_____ _____

Medical Practitioner Signature Date

Name_____ _____

Provider Initials