

**COVENTRY PUBLIC SCHOOLS
COVENTRY, RI 02816**

Please take this form to your physician

PHYSICAL EXAMINATION

DATE _____

1. NAME _____ ADDRESS _____

2. S M W D M F AGE _____ TEL NO. _____ OCCUPATION _____

3. OCCUPATIONAL HISTORY LAST EMPLOYER _____ FROM _____ TO _____

4. SS# _____ DATE OF BIRTH _____

5. FAMILY PHYSICIAN _____ LAST VISIT _____ REASON _____

6. WORK ALLERGIES _____ LAST HOSPITALIZATION _____ REASON _____

7. MILITARY SERVICE _____ TYPE OF DISCHARGE _____ DISABILITY YES () NO ()

8. PERSONAL HISTORY

Tuberculosis	Heart Trouble	Fainting	Diabetes
Emotional Illness	Dizziness	Rheumatism	Cancer
Alcoholism	Hay Fever	Asthma	Injuries
Drug Habit	Blood in Urine	Skin Disease	Arthritis
Headaches	Other Illness	Epilepsy	Syphilis
Cigarettes/Day	High Blood Pressure	Kidney Disease	Bladder, Prostate
	Meds taken Regularly		

9. HISTORY OF BACK INJURY _____

10. FAMILY HISTORY _____

11. PHYSICAL EXAMINATION: HEIGHT _____ WEIGHT _____ TEMP. _____ B.P. _____ RESP. _____

VISION - DISTANT UNCORRECTED RT. _____ LT. _____ NEAR UNCORRECTED RT. _____ LT. _____

VISION - DISTANT CORRECTED RT. _____ LT. _____ NEAR CORRECTED RT. _____ LT. _____

EARS - RT. _____ LT. _____ NOSE _____ THROAT _____ TONSILS _____ TEETH _____

GUMS _____ NECK _____ HEART _____ LUNGS _____ SPINE _____

UPPER EXT. _____ LOWER EXT. _____ ABDOMEN _____ HERNIA _____ RINGS _____

VARICOCELE _____ VARICOSITIES _____ MAJOR HAND () R () L

RECTAL EXAM _____ STOOL _____

12. MENSTRUAL PERIOD - DISABLING BECAUSE OF PAIN _____ DATE OF LAST PERIOD _____

PREGNANT () YES () NO

13. DETAILS OF ABNORMAL FINDINGS _____

14. ARE YOU UNDER TREATMENT OR TAKING MEDICATION _____ HEART OR BLOOD PRESSURE PILLS _____

HAVE YOU LOST MORE THAN ONE WEEK THROUGH ILLNESS OR INJURY _____

ARE YOU SENSITIVE TO OR HAD REACTION TO DRUGS _____

15. WORK LIMITATIONS AND/OR RECOMMENDATIONS

<input type="checkbox"/>	CLASS 1 - ACCEPTABLE FOR IMMEDIATE EMPLOYMENT
<input type="checkbox"/>	CLASS II - ACCEPTABLE FOR EMPLOYMENT AFTER IMPAIRMENTS HAVE BEEN CORRECTED
<input type="checkbox"/>	CLASS III - ACCEPTABLE FOR EMPLOYMENT WITH RESTRICTIONS
<input type="checkbox"/>	CLASS IV - NOT ACCEPTABLE FOR EMPLOYMENT

I have discussed the examination results and the above recommendations with patient.

EXAMINER _____ MD _____ DATE _____