



# Vineyard Medical Care

364 State Road, Vineyard Haven MA 02568  
PH: 508-693-4400 Fax: 508-693-2098

## Pre-Employment History and Physical Form

### Personal Data

Name (Last, First, MI):			SSN:		
Date of Birth: / /		Age:	Ethnicity:		
Phone Numbers:	Home ( ) -		Mobile ( ) -		Work ( ) -
Address:					
(street)		(city)		(state)	(zip)
Job Title & Department:			Union: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:		

### Current Medical Provider

Name of doctor:			Phone Number: ( ) -		
Address:					
(street)		(city)		(state)	(zip)

### Prior Employment Start with most recent job

	Job Title	Employer/City/State	Dates of employment (mo/yr)
1			/ to /
2			/ to /
3			/ to /
4			/ to /

### Review of Symptoms

Do you have any of the following?:	Yes	No	Do you have any of the following?:	Yes	No
Weight loss / Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Difficulty with vision / Wear lenses or glasses			Abdominal pain		
Dizziness / Vertigo			Diarrhea/constipation		
Difficulty hearing			Irregular periods		
Seasonal allergies			Frequent urinary tract infections		
Sinus problems			Kidney stones		
Tiredness or falling asleep during the day			Back pain		
Unable to tolerate heat or cold			Joint pain or swelling		
Shortness of breath with or without exertion			A history of broken bones		
Wheezing			Swelling of the legs		
Cough			Skin problems (rash, eczema, psoriasis)		

### Vaccination History/Communicable Diseases

Have you had:	Yes	No	Unsure
The standard series of childhood vaccinations (to the best of your knowledge)?			
The disease "chicken pox" or the chicken pox vaccine (varicella)?			
A tetanus/diphtheria booster shot within the last 10 years?			
Hepatitis B vaccination (this is a series of three injections spaced several months apart)?			
The disease "Tuberculosis"?			
A positive tuberculosis test (also called a PPD or Tine test)?			
Vaccination against tuberculosis with BCG (this is uncommon in the United States)?			

**Have you ever had:**  a car accident  loss of consciousness  heart attack  loss of vision  abnormal heart rhythm  
 seizure  panic attacks  head injury  stroke  paralysis  back injury  psychiatric disorder

**Current Medical Conditions** Those that you are currently experiencing and/or receiving treatment for (such as diabetes, high blood pressure, migraine)

Please List		Date of onset (mo/yr)	Please List		Date of onset (mo/yr)
1		/	5		/
2		/	6		/
3		/	7		/
4		/	8		/

**Past Medical Conditions** Those that you have had in the past but have recovered from (such as childhood asthma, gestational diabetes)

Please List		Date of onset (mo/yr)	Please List		Date of onset (mo/yr)
1		/	3		/
2		/	4		/

**Surgeries/Hospitalizations** List type of surgery (such as gall bladder) or condition for which you were hospitalized (such as heart attack, pneumonia)

Please List		Date (mo/yr)	Please List		Date (mo/yr)
1		/	4		/
2		/	5		/
3		/	6		/

**When was your last visit to the emergency room?** \_\_\_\_\_ **For what symptom/condition?** \_\_\_\_\_

**Family History** Please list any conditions that run in your biological family (even if relative is deceased)

Please List		Circle affected relative	Please List		Circle affected relative
1		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	4		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather
2		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	5		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather
3		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather	6		Father / Mother / Sister / Brother / Child / Grandmother / Grandfather

**Medications** Please include non-prescription medications, vitamins, and herbal supplements in addition to prescription medications

1		4		7	
2		5		8	
3		6		9	

**Do you have any allergies to medications or other substances?**  Yes  No (if yes, please specify on next line)

**Social History**

Do you smoke cigarettes? <input type="checkbox"/> yes / <input type="checkbox"/> no / <input type="checkbox"/> used to smoke, but quit		If yes, how many cigarettes per day? _____ Per week? _____	
How many alcoholic drinks do you consume per day? _____ Per week? _____		Do you use illicit/illegal drugs? <input type="checkbox"/> yes / <input type="checkbox"/> no	
How many minutes of exercise do you get per day? _____		How many days a week do you exercise? _____	
How many hours of television do you watch per day? _____		How many times do you eat fast food per week? _____	



**Physical Examination**

Height	Weight	BMI	Blood Pressure	Pulse	Respirations	Temperature

Vision:                   Uncorrected / Corrected (circle): OD - \_\_\_/\_\_\_ OS - \_\_\_/\_\_\_ OU - \_\_\_/\_\_\_

HEENT: \_\_\_\_\_

Neck: \_\_\_\_\_

Chest/Lungs: \_\_\_\_\_

Heart: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Neurological: \_\_\_\_\_

Skin: \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

Assessment: \_\_\_\_\_

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**Practitioner signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_