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 Phone Number: _____
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	Chemicals 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 an impairment or disability award? ☐ Yes ☐ No

Additional Information: Explain 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.

_____
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 Diseases	☐ 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

Physical Evaluation - - -Physician please complete:

Blood Pressure_____

Pulse _____

Height _____

Weight _____

Visual Acuity	**Far**			**Near**		
___With Glasses ___Without Glasses	L 20/____	R 20/____	Both 20/____	L 20/____	R 20/____	Both 20/____

Color Vision: ( ) Normal ( ) Abnormal

Depth Perception: ( ) Acceptable ( ) Not Acceptable

Physical Examination- Continued: Note abnormalities in the space provided:

General Appearance	( ) Normal	( ) Abnormal	_____
Skin / Scars	( ) Normal	( ) Abnormal	_____
Eyes	( ) Normal	( ) Abnormal	_____
Ears	( ) Normal	( ) Abnormal	_____
Teeth and gums	( ) Normal	( ) Abnormal	_____
Nose, throat, tonsils	( ) Normal	( ) Abnormal	_____
Neck / thyroid	( ) Normal	( ) Abnormal	_____
Heart / Murmur	( ) Normal	( ) Abnormal	_____
Lungs	( ) Normal	( ) Abnormal	_____
Thorax	( ) Normal	( ) Abnormal	_____
Abdomen	( ) Normal	( ) Abnormal	_____
Hernia	( ) Normal	( ) Abnormal	_____
Back / Spine	( ) Normal	( ) Abnormal	_____
Extremity Strength	( ) Normal	( ) Abnormal	_____
Phalen's	( ) Normal	( ) Abnormal	_____
Tinel's	( ) Normal	( ) Abnormal	_____

Summary of findings:_____

_____

_____

_____

_____ _____

Physician or Nurse Signature **Date**

*8701669 –11/01