

Employee Health Service
 George Washington University Hospital
 900 23rd Street, NW, Suite G-1092 • Washington, DC 20037
 202/715-4275 (Phone)
 202/715-4587 (Fax)

Name _____ Male Female Date of birth _____

Home address _____ City: _____ State: _____ Zip code: _____

Home telephone _____ Work number _____

Position _____ Department _____ Shift _____

MEDICAL HISTORY

Do you have any allergies to food, medications, or other substances? No Yes If yes, please list: _____

Do you take any medications on a daily basis? No Yes If yes, please list: _____

Do you have any medical conditions? No Yes If yes, please list: _____

Have you had any operations in the past year? No Yes If yes, please list: _____

Have you had any work-related injuries or blood/body fluid exposures within the past year No Yes If yes, please describe: _____

HEALTH BEHAVIORS

For Women	For Men	For Both
Do you practice monthly breast exams? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last pap smear: _____ Date of last mammo: _____ Date of last colon test: _____	Do you practice monthly testicular exams? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last prostate exam: _____ Date of last colon test: _____	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many drinks per week? _____ Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times per week? _____ Do you smoke now? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much? _____ ppd Do you have regular dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY MEDICAL HISTORY

Does anyone in your family have: high blood pressure _____, diabetes _____, colon cancer _____, breast cancer _____, heart disease _____, prostate cancer _____,

THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



ANNUAL PHYSICAL EXAMINATION

80-633 (12/10)

Patient Label

To Be Completed by Examiner

Height	Weight	BP	Pulse
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	Normal (✓)	Comments for abnormal findings
General appearance		
Skin		
Eyes		
ENT		
Mouth/teeth/gums		
Neck		
Lungs		
Heart		
Abdomen		
Upper extremities		
Lower extremities		
Back/spine		
Neurologic		
Mental status		

ASSESSMENT/PLAN:

_____ History of + PPD. ROS negative, physical examination WNL, and annual TB surveillance negative for active disease. Chest xray on file.

_____ History of + PPD. ROS, physical examination, and/or annual TB surveillance suggest active disease. Chest xray ordered. See Progress Note.

_____ PPD planted.
Date of PPD: _____ Neg: _____ Pos: _____

_____ Immunization reviewed/updated: Td/Tdap HBV MMR Other: _____

_____ **Final Clearance** _____

_____ Person is qualified to continue to perform the essential functions of the job, with or without accommodation. Accommodation needed, if any: _____

_____ Person is not qualified to continue to perform the essential functions of the job, with or without accommodation, for the following reason: _____

Signature of Examiner

Date

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ANNUAL PHYSICAL EXAMINATION