Holland Medicenter
335 N. 120th Ave
Holland, MI 49424
Phone: (616) 392-5222
Fax: (616) 392-3653

Pre-Placement History & Examination

Employee Name:_____ SSN: _____ DOB: _____ Age:____ Date: _____

Address:_____ Employee Phone:_____

Employer: _____ Position Applying For:_____

Do You Now Have or Have You Ever Had...

	Yes	No		Yes	No
1. Heart Disease or high blood pressure	( )	( )	19. Significant weight gain or loss	( )	( )
2. Tuberculosis or other lung disease	( )	( )	20. Any physical defects or deformities	( )	( )
3. Ears, eyes, nose, or throat problems	( )	( )	21. Seizures, fainting, anxiety, depression	( )	( )
4. Asthma, chronic cough, COPD, allergies	( )	( )	22. Alcohol, drug, or other addiction	( )	( )
5. Bleeding disorder	( )	( )	23. Wear glasses or contacts	( )	( )
6. Back or neck pain or injury	( )	( )	24. Any occupational disease or injury	( )	( )
7. Shoulder or arm/hand pain or injury	( )	( )	25. Exposure to dust, fumes, chemicals	( )	( )
8. Knee pain or injury	( )	( )	26. Exposure to excessive noise	( )	( )
9. Broken bones or dislocated joints	( )	( )	27. Worked in a coal mine or foundry	( )	( )
10. Arthritis or joint pain	( )	( )	28. Changed employment for health reasons	( )	( )
11. Tendonitis, ganglion cysts, carpal tunnel	( )	( )	29. An auto accident requiring hospitalization	( )	( )
12. Numbness or tingling in hands or feet	( )	( )	30. Stayed overnight in the hospital	( )	( )
13. Liver, stomach, or bowel problems	( )	( )	31. Operations and/or surgeries	( )	( )
14. Skin trouble or eczema	( )	( )	32. Are you receiving medical treatment for any condition?	( )	( )
15. Varicose veins or leg sores	( )	( )	33. Are you taking any medications?	( )	( )
16. Diabetes or other endocrine disorder	( )	( )	34. Are you allergic to any medications?	( )	( )
17. Hernia or worn a truss	( )	( )	35. Do you or have you ever smoked?	( )	( )
18. Cancer or tumor	( )	( )			

Briefly describe all "yes" answers - _____

_____

_____

I certify that I have answered truthfully questions regarding my health history and have not knowingly withheld any information concerning my health status either past or present. I agree that all findings of this examination may be submitted to my employer.

_____ _____
Patient Signature Date

EXAMINER ONLY:

Height:_____ Wt:_____ BP:_____ Pulse:_____ UA Glucose:_____ UA Albumin:_____ UA S.G._____ UA Blood:_____

Visual Acuity: Corrected / Uncorrected Right Eye: 20/_____ Left Eye: 20/_____ Both Eyes: 20/_____

HENT: ( ) N ( ) A
Heart: ( ) N ( ) A
Lungs: ( ) N ( ) A
Abdomen: ( ) N ( ) A
Skin: ( ) N ( ) A
Neurologic: ( ) N ( ) A
Neck/Back
Inspect: ( ) N ( ) A
ROM: ( ) N ( ) A
Shoulders
Inspect: ( ) N ( ) A
ROM: ( ) N ( ) A
Strength: ( ) N ( ) A
Elbows
Inspect: ( ) N ( ) A
ROM: ( ) N ( ) A
Strength: ( ) N ( ) A

Wrist/Hands
Inspect: ( ) N ( ) A
ROM: ( ) N ( ) A
Strength: ( ) N ( ) A
Finklestein's ( ) N ( ) A
Phalens ( ) N ( ) A
Tinel's ( ) N ( ) A
Hips
ROM: ( ) N ( ) A
SLR: ( ) N ( ) A
Knees
Inspect: ( ) N ( ) A
ROM: ( ) N ( ) A
Strength: ( ) N ( ) A

Based upon the history and physical exam of this employee:

_____1. No medical contraindications to performing this job without accomodation.
_____2. Recommend Accomodations-See Preplacement Report.
_____3. Medical hold / Awaiting medical records for further review
_____4. Further testing is required to fully evaluate risk

_____
Provider Signature