

UNIVERSITY OF FLORIDA PREPLACEMENT EXAM: MEDICAL HISTORY

NAME _____ SSN _____
Last First MI UF ID _____

ADDRESS _____

PHONE # _____ BIRTH DATE _____

As part of our effort to insure that your employment with the University does not worsen any pre-existing medical problem we ask that you answer the following questions.

This history and physical is not a substitute for a comprehensive examination by your personal physician and does not include cancer screening, cholesterol testing, etc. Any of our findings will be shared with you and your physician upon request. We are not authorized to treat conditions detected during this exam.

Have you ever been treated:

NO YES

- Seizures _____ Anemia _____
- Loss of Consciousness _____ Arthritis _____
- Severe Headaches _____ Neck Injury _____
- Heat Disorders _____ Shoulder Injury _____
- Hayfever/Allergies _____ Wrist Problem _____
- Indoor Air Problems _____ Finger Injury _____
- Thyroid Disease _____ Back Strain _____
- Asthma _____ Herniated Disc _____
- Pneumonia _____ Hip Problem _____
- Tuberculosis (TB) _____ Knee Injury _____
- High Blood Pressure _____ Ankle Injury _____
- Heart Disease _____ Foot Problem _____
- Ulcers _____ Emotional Disturbance _____
- Liver Disease _____ Surgery _____
- Kidney Stones _____ Work related injury/illness _____
- Diabetes _____

Examiner Comments: _____

Medication allergies: _____

Current medications: _____

Do you have any health conditions that you think may hinder your performance on the job or may require your work to be modified

NO _____ YES _____ , _____

DATE _____ SIGNATURE _____ REVIEWED BY _____

UNIVERSITY OF FLORIDA PREPLACEMENT PHYSICAL EXAM Position # _____

NAME _____ UF ID _____ SSN _____

POSITION _____ HEIGHT _____ WEIGHT _____

VISION _____ / _____ BLOOD PRESSURE _____ PULSE _____
uncorrected corrected

TITMUS _____ COLOR VISION _____

AC Asbestos BBP Diving Generic Hearing Cons Haz Waste NR
 Pesticides Police Respirator N-95 Patient Contact CDL

OBSERVATIONS:

General Appearance	NL__ ABNL__	Neuro	NL__ ABNL__
Skin/Scars	NL__ ABNL__	Neck	NL__ ABNL__
Eyes	NL__ ABNL__	Upper Extremities	NL__ ABNL__
Thyroid	NL__ ABNL__	Back	NL__ ABNL__
Chest/Lungs	NL__ ABNL__	Lower Extremities	NL__ ABNL__
Heart/Vessels	NL__ ABNL__	Abdomen/Hernia	NL__ ABNL__

COMMENTS: _____

IMMUNIZATIONS:

Tdap _____ MMR _____ Chicken Pox _____ Hep B _____
RABIES _____ Other _____

OTHER TESTS:

PPD _____ CXR _____ PFT _____ EKG _____ CBC _____ UA _____
Chem Profile _____ ALT/AST _____ BUN _____ Serum Banking _____ Ferritin _____
Q Fever Titer _____ Toxoplasmosis Titer _____ Varicella Titer _____ Audiometry _____
Cholinesterase Baseline _____ Other _____

RECOMMENDATIONS:

- No job specific limitations
- Job specific limitations: _____

I have been advised of the results of the medical examination I have just undergone. I understand that should I have medical limitations specific to the job I have been offered, I must advise my employer of such limitations PRIOR to starting work.

Signature Date

Examiner (MD, PA, ARNP) Printed Name Signature Date