TEMPLE UNIVERSITY®
Employee Health Services

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: ☐ Yes ☐ 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? □ yes / □ no / □ 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? □ yes / □ 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? _____

Occupational Assessment

Please answer the following questions regarding the job for which you have been hired:	Yes	No	Unsure
Will you be required to wear respiratory protection (e.g., N95 mask or cartridge respirator)?			
Do you anticipate working with hazardous chemicals or materials, infectious agents, or laboratory animals?			
Is there a chance that you will be exposed to human blood or body fluids as a result of routine job duties?			
If your job involves work at a computer, have you had or are you experiencing any discomfort, pain, or numbness when working at your desk?			
Will you be required to drive a vehicle for any reason?			
Will you be required to move heavy objects regularly (i.e., greater than 50 pounds occasionally or 25 pounds frequently)?			
Have you ever had an occupational injury/illness before (e.g., back strain, needle-stick, chemical exposure)?			

Do you have any condition (physical, medical, or psychological) that would require special accommodations in order for you to perform your job? ☐ **Yes** ☐ **No** (if yes, please specify on next lines)

_____

_____

Signature of employee: _____ Date: _____

Practitioner Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Practitioner signature: _____ Date: _____