Basic Exam

Company: _____

_____

Name of Applicant: _____ D.O.B _____ Sex: ☐ Male ☐ Female

Address: _____ (Street) _____ (City/Town) _____ (State) _____ (Zip Code)

Family Physician: _____ Date & Reason Consulted _____

Address: _____ (Street) _____ (City/Town) _____ (State) _____ (Zip Code)

Treatment and/or Medication Prescribed? ☐ Yes ☐ No (If Yes, give details in #8 Remarks Section)

	YES	NO
1. Have you ever consulted any medical practitioner for, or so far as you know, ever been treated for:		
A. Any disorder of eyes, ears, nose or throat, including speech impairment or loss of sight?	☐	☐
B. Any disease of the lungs or respiratory tract such as tuberculosis, emphysema, pleurisy, asthma, hayfever, spitting blood, or persistent hoarseness or coughing?	☐	☐
C. Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins?	☐	☐
D. Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis?	☐	☐
E. Any disorder of the prostate, bladder, kidneys or genito-urinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic?	☐	☐
F. Any brain or nervous system disorder, e.g., epilepsy, convulsions, fainting or loss of consciousness, mental illness, constant nervousness or severe headaches?	☐	☐
G. Any alcoholism or excessive use of alcohol or any drug habit? Any treatment or hospitalization?	☐	☐
H. Any impairment of function, or loss of hand, arm, shoulder, foot, leg or hip, or back disorder?	☐	☐
I. Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema?	☐	☐
2. Have you ever:		
A. Had a surgical operation?	☐	☐
B. Been told to have an operation that wasn't performed?	☐	☐
C. Had any diagnostic procedures, e.g. x-ray, electro-cardiogram?	☐	☐
D. Lived with someone who has had T.B. in the last 2 years?	☐	☐
E. Had a weight change in the past year? If yes, reason? (List below)	☐	☐
F. Had a physical or mental condition that caused you to be deferred, rejected or discharge from the armed forces?	☐	☐
G. Ever applied for or received any pension or benefits for sickness, disability or accident?	☐	☐

	YES	NO
3. Other than previously stated, as far as you know, have you in the last 5 years:		
A. Had any illness, disease or injury?	☐	☐
B. Been admitted to, or been advised to enter, a hospital or sanitarium, etc.	☐	☐
C. Consulted any medical practitioner for any reason (including check-ups?)	☐	☐
D. Any reason to feel you are not in good health?	☐	☐
E. Are you taking any medication or drugs?	☐	☐
4. For women only:		
A. Are you pregnant? If yes, please give month of pregnancy, any previous pregnancies, and any complications of those pregnancies, if any. (list below)	☐	☐
B. Any disorder of the breasts or female organs?	☐	☐

5. A. Family History

Family Record	Age if Living	Condition of Health If not "Good," give details	Age at Death	Cause Of Death
Father				
Mother				
Brothers				
Sisters				

	YES	NO
B. Any family history of diabetes, cancer, hypertension, heart or kidney disease, mental illness or suicide?	☐	☐
6. Do you participate in regular exercise? If yes, describe type and frequency. (list below)	☐	☐
7. Smoking Habits: Do you smoke cigarettes?	☐	☐
If yes, packs per day (list below)		
If non-smoker, did you ever smoke cigarettes?	☐	☐
If yes, for how long, packs per day and when did you quit? (list below)		

8. Remarks: Please give full details for any questions above answered "Yes".

Question #	Dates and Duration	Physician's Name, Hospital or Company, Address, City, State and Zip Code Nature of Condition, Treatment, Results, Reasons and Other Information

Basic Exam (Continued)

9. Pulse _____ per/minute ☐ Regular ☐ Irregular

Number of Irregularities, if any _____

10. Blood Pressure

	1st Reading	2nd Reading	3rd Reading
Systolic			
Diastolic			

Blood Pressure: Record 1 reading, if systolic over 140 or diastolic over 90, take second and third readings after 10 minutes of rest.

11. Height _____ (without shoes)

Weight _____

12. Urinalysis (Dipstick)

Glucose _____

Albumin _____

13. Measurements (Males Only)

Chest at full inspiration _____

Chest at forced expiration _____

Abdomen at umbilicus _____

14. Did you weigh? ☐ Yes ☐ No

Did you measure? ☐ Yes ☐ No

15. Obvious abnormalities:

16. Remarks:

I HEREBY DECLARE that, to the best of my knowledge and belief, the information given in these answers to the APPS-PORTAMEDIC Examiner is correctly recorded, complete and true, and I agree that the Company, believing them to be true, shall rely and act upon them accordingly.

Dated at _____ on _____ 19 _____

Witnessed by _____
APPS-Portamedic Examiner

Signature of Person Examined _____

APPS-PORTAMEDIC Branch Address:

APPS - PORTAMEDIC®
One Jericho Plaza
Jericho, NY 11753

Health Survey Information Authorization

I hereby authorize the release of this medical information to APPS-PORTAMEDIC and my Employer ☐ Prospective Employer ☐ Other ☐

Signature of Applicant Date

Signature of Witness/Examiner Date

Please Print Name of Applicant

Please Print Name of Witness/Examiner

This is a non-state specific generic exam form.