2000 Cliff Mine Road, Park West Two, Suite 110, Pittsburgh, PA 15025
412-494-4550

Hazwoper Employee General Physical
Employee Health History

To be completed by the employee/applicant:

Name: _____ **SS#**_____ **Date of Birth** _____

Address: _____ **Phone:** _____

_____ **Employer/Company Name:** _____

_____

Please check any of the following illnesses that you have been diagnosed as having in the past or present.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Pneumothorax (collapsed lung)
- ☐ Back problems/injury
- ☐ Chronic Bronchitis
- ☐ Angina
- ☐ Seizures/Epilepsy
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Thyroid Disease
- ☐ Varicose Veins
- ☐ Heart Attack
- ☐ Silicosis
- ☐ Heart Arrhythmia
- ☐ Stroke
- ☐ Ulcers
- ☐ Asthma
- ☐ Glaucoma
- ☐ Emphysema
- ☐ Frequent UTI's
- ☐ Asbestosis
- ☐ Pneumonia
- ☐ Eczema

Do you currently smoke tobacco, or have you smoked tobacco in the last month? ☐ Yes ☐ No

Have you ever been hospitalized and/or had surgery (other than pregnancy)? _____
If yes, than please describe the illness and date:

Illness/Operation: Date: _____
_____ _____
_____ _____

Please list all prescription and over-the-counter medications you are currently taking. Provide dosage if possible:
_____
_____

Please list any allergies you have. If you are allergic to a medication, please describe the nature of the reaction to the medication:
_____
_____

Please check any of the following problems you have had in the past or are currently having:

- ☐ Severe headache
- ☐ Difficulty hearing
- ☐ Visual difficulty
- ☐ Frequent sore throat
- ☐ Neck pain
- ☐ Back pain/injury
- ☐ Nervousness
- ☐ Racing of heart
- ☐ Weight Loss
- ☐ Recent change in appetite
- ☐ Frequent nausea or vomiting
- ☐ Severe abdominal pain
- ☐ Frequent diarrhea
- ☐ Chronic cough
- ☐ Chest pain/tightness
- ☐ Arthritis
- ☐ Joint Swelling
- ☐ Skin problems
- ☐ Head injury
- ☐ Dizziness
- ☐ Numbness/tingling
- ☐ Hernias
- ☐ Depression
- ☐ Swelling of feet or ankles

If you have any problems or illness not listed above or have additional comments about any item you checked above, please note them below:

_____
_____
_____
_____

Please check any of the following hazard chemicals or materials or under any of the conditions you have worked with in the past or are currently working in:

☐ Asbestos	☐ Coal (mining)	☐ Silica (sand blasting)
☐ Iron	☐ Tungsten/cobalt (grinding/welding)	☐ Tin
☐ Dusty Environments	☐ Beryllium/Arsenic/Cadmium	☐ Aluminum
☐ Dioxin/Herbicides	☐ Chlorinated Ethanes/Hydrocarbons	☐ Chromium/Lead/Mercury

If yes, describe these exposures:

_____
_____
_____

Provide the following information, if you know it, for each toxic substance that you have been exposed to over the past year.

Name of first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

I hereby certify that the information I have furnished on this form or to the examining physician is true and correct. I understand that falsification or omission may result in denial or dismissal from employment. I authorize the attending physician to disclose any findings made by him/her to the employer in regards to my employment.

_____ _____

Employee/Applicant - PRINT **Date**

_____

Employee/Applicant - Signature

Name _____ D.O.B._____

Vital Signs BP_____ Pulse _____ Ht. _____ Wt. _____ Temp. _____

	Normal	Abnormal	For Any Relevant Findings Please Make a Notation
General			
Skin			
Head			
Eyes			
Ears			
Nose/Throat			
Neck			
Lymph Nodes			
Chest/Lungs			
Heart			
Abdomen			
Extremities			
Back			
Neurological			

I have informed the applicant/employee of any abnormalities on the exam.

_____ _____
Signature of examining health care professional Date

PRE-EMPLOYMENT/ANNUAL/ FIT FOR DUTY PHYSICALS

_____ Individual is in good health based upon the above information.
_____ Individual is capable of performing above indicated position
_____ Individual is not capable of performing above indicated position at this time.
_____ Individual is capable of performing above indicated position with the following recommendations:
_____
_____ Further information is needed prior to making fitness for duty determination.
_____ Based on the information obtained and physical examination, this individual appears to be free from communicable diseases.

_____
Signature

The above physical examination and testing has been reviewed by

Physician's Signature_____

Print Physician Name_____

Date:_____