SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
25631 PETER A. HARTMAN WAY MISSION VIEJO, CA 92691

MEDICAL HISTORY

(FILL OUT IN BLACK INK PLEASE)

PLEASE READ CAREFULLY AND ANSWER ALL QUESTIONS. THIS EXAMINATION WILL ASSIST THE SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT IN PLACING YOU IN A JOB WHICH IS SAFE FOR YOU AND FOR OTHERS BASED ON YOUR PHYSICAL ABILITY.

☐ MALE ☐ FEMALE

NAME: LAST FIRST MIDDLE

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE:( )

BIRTHDATE (Ex: 12/16/1960):

SOC. SEC. NUMBER:

FOR PERSONNEL USE ONLY

JOB TITLE:

SITE LOCATION:

LIST HOSPITALIZATIONS:

DATE	REASON FOR HOSPITALIZATION	HOSPITAL NAME AND LOCATION

LIST INJURIES AND ILLNESSES YOU HAVE HAD:

DATE	INJURY OR ILLNESS	HOW LONG WERE YOU INJURED/ILL

WORK/SERVICE HISTORY

1. HAVE YOU EVER RECEIVED TREATMENT FOR AN INJURY OR ILLNESS SUSTAINED AT WORK? ☐ YES ☐ NO
2. HAVE YOU EVER RECEIVED A VETERAN'S PENSION FOR A SERVICE CONNECTED DISABILITY? ☐ YES ☐ NO
3. WERE YOU, FOR MEDICAL REASONS, EVER REJECTED FOR LIFE INSURANCE OR BY THE ARMED FORCES? ☐ YES ☐ NO
4. HAVE YOU EVER BEEN EXPOSED TO EXTENSIVE RADIATION IN MEDICAL DIAGNOSIS OR TREATMENT? ☐ YES ☐ NO
5. HAVE YOU EVER WORKED WITH RADIATION SOURCES, RADIATION PRODUCING EQUIPMENT OR RADIOACTIVE MATERIALS? ☐ YES ☐ NO
6. HAVE YOU WORKED IN A DUSTY TRADE, SUCH AS MINING, FOUNDRY OR POTTERY? ☐ YES ☐ NO
7. HAVE YOU EVER HAD ILL EFFECTS FROM THE WORK YOU HAVE DONE? ☐ YES ☐ NO
8. HAVE YOU EVER RECEIVED A PENSION FOR A PHYSICAL DISABILITY? ☐ YES ☐ NO
9. HAVE YOU EVER BEEN ADVISED TO HAVE A SURGICAL OPERATION OR MEDICAL TREATMENT THAT HAS NOT BEEN DONE? ☐ YES ☐ NO

PLEASE EXPLAIN DETAILS TO ALL YES ANSWERS TO THE ABOVE ITEMS (USE EXTRA PAPER IF NEEDED)

_____

_____

10. HOW MANY DAYS OF WORK HAVE YOU LOST BECAUSE OF SICK LEAVE IN THE PAST TWELVE MONTHS?
11. ARE YOU UNDER A DOCTOR'S CARE NOW? _____ IF YES, REASON: _____
12. ARE YOU TAKING ANY DRUGS OR MEDICINES NOW? _____ IF YES, LIST THEM: _____
13. MY PRESENT HEALTH IS: ☐ EXCELLENT ☐ GOOD ☐ FAIR
14. I EXERCISE: ☐ NEVER ☐ RARELY ☐ 1-3 DAYS PER WEEK ☐ MORE THAN 3 DAYS PER WEEK
15. MY PERSONAL OR FAMILY PHYSICIAN HAS PERFORMED A PHYSICAL EXAMINIATION ON ME WITHIN THE LAST 12 MONTHS: ☐ YES ☐ NO

PLEASE ANSWER EACH AND EVERY QUESTION BELOW EITHER YES OR NO. IF "YES", GIVE APPROXIMATE YEAR. HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING (LEAVE NO BLANKS):

1. ALLERGY TO CHEMICALS	☐ YES ☐ NO ____	25. GALL BLADDER TROUBLE	☐ YES ☐ NO ____	49. RAPID HEART BEAT	☐ YES ☐ NO ____
2. ALLERGY – OTHER	☐ YES ☐ NO ____	26. GOUT	☐ YES ☐ NO ____	50. RASHES	☐ YES ☐ NO ____
3. ANEMIA	☐ YES ☐ NO ____	27. HEADACHES (SEVERE)	☐ YES ☐ NO ____	51. RHEUMATIC FEVER	☐ YES ☐ NO ____
4. ARTHRITIS	☐ YES ☐ NO ____	28. HEART TROUBLE	☐ YES ☐ NO ____	52. SCIATICA	☐ YES ☐ NO ____
5. ASTHMA	☐ YES ☐ NO ____	29. HEMORRHOIDS	☐ YES ☐ NO ____	53. SEIZURES	☐ YES ☐ NO ____
6. BACK INJURY	☐ YES ☐ NO ____	30. HEPATITIS	☐ YES ☐ NO ____	54.SEVERE MENSTRUAL CRAMPS	☐ YES ☐ NO ____
7. BACK TROUBLE	☐ YES ☐ NO ____	31. HERNIA	☐ YES ☐ NO ____	55. SHORTNESS OF BREATH	☐ YES ☐ NO ____
8. BLOOD CLOT IN VEIN	☐ YES ☐ NO ____	32. HIGH BLOOD PRESSURE	☐ YES ☐ NO ____	56. STOMACH TROUBLE	☐ YES ☐ NO ____
9. BROKEN BONES	☐ YES ☐ NO ____	33. INDIGESTION (CHRONIC)	☐ YES ☐ NO ____	57. STROKE	☐ YES ☐ NO ____
10. BRONCHITIS	☐ YES ☐ NO ____	34. IRREG/ABNORMAL PERIODS	☐ YES ☐ NO ____	58. SWELLING OF ANKLES/FEET	☐ YES ☐ NO ____
11. CANCER	☐ YES ☐ NO ____	35. JAUNDICE	☐ YES ☐ NO ____	59. SYPHILIS	☐ YES ☐ NO ____
12. CHRONIC COUGH	☐ YES ☐ NO ____	36. KIDNEY TROUBLE	☐ YES ☐ NO ____	60. THYROID TROUBLE	☐ YES ☐ NO ____
13. COLITIS	☐ YES ☐ NO ____	37. LEUKEMIA	☐ YES ☐ NO ____	61. TINGLING OF ARMS/LEGS	☐ YES ☐ NO ____
14. DERMATITIS	☐ YES ☐ NO ____	38. MALARIA	☐ YES ☐ NO ____	62. TROPICAL DISEASE	☐ YES ☐ NO ____
15. DIABETES	☐ YES ☐ NO ____	39. MIGRAINE	☐ YES ☐ NO ____	63. TUBERCULOSIS	☐ YES ☐ NO ____
16. DISK INJURY (SPINAL)	☐ YES ☐ NO ____	40. MUSCLE DISEASE	☐ YES ☐ NO ____	64. TUMORS	☐ YES ☐ NO ____
17. DIZZINESS	☐ YES ☐ NO ____	41. NECK INJURY	☐ YES ☐ NO ____	65. ULCER	☐ YES ☐ NO ____
18. EAR TROUBLE	☐ YES ☐ NO ____	42. NUMBNESS OF ARMS/LEGS	☐ YES ☐ NO ____	66. ULCERATIVE COLITIS	☐ YES ☐ NO ____
19. ECZEMA	☐ YES ☐ NO ____	43. PAIN IN CHEST	☐ YES ☐ NO ____	67. VOMITING OF BLOOD	☐ YES ☐ NO ____
20. EMPHYSEMA	☐ YES ☐ NO ____	44. PEPTIC ULCER DISEASE	☐ YES ☐ NO ____	68. VARICOSE VEINS	☐ YES ☐ NO ____
21. EYE DISEASE	☐ YES ☐ NO ____	45. PLEURISY	☐ YES ☐ NO ____	69. VASCULAR DISEASE	☐ YES ☐ NO ____
22. FAINTING SPELLS	☐ YES ☐ NO ____	46. PNEUMONIA	☐ YES ☐ NO ____	70. WHIPLASH	☐ YES ☐ NO ____
23. FEMALE DISORDERS	☐ YES ☐ NO ____	47. POLIOMYELITIS	☐ YES ☐ NO ____	71. OTHER_____	☐ YES ☐ NO ____
24. FIBROMYITIS	☐ YES ☐ NO ____	48. PSORIASIS	☐ YES ☐ NO ____	72. OTHER_____	☐ YES ☐ NO ____

HEARING TEST

EITHER/OR:

HEARING (WHISPER TEST): LEFT_____ RIGHT_____

AUDIO SCREEN:

RIGHT EAR

500	1000	2000	3000	4000	6000	

LEFT EAR

500	1000	2000	3000	4000	6000	

VISUAL ACUITY

GLASSES OR CONTACTS WORK: NONE_____ ALWAYS_____ BIFOLCAL_____ FAR/NEAR_____

	CORRECTED	UNCORRECTED
L		
R		
BOTH		

ISHIHARA PASS_____ FAIL_____
RED/GREEN/YELLOW PASS_____ FAIL_____
PERIPHERAL VISION PASS_____ FAIL_____

VITAL SIGNS

TEMP_____ PULSE_____ BLOOD PRESSURE_____ HEIGHT_____ WEIGHT_____

URINALYSIS: S.G._____ ALB_____ GLU_____ KET_____ BLD_____

T.B. TEST RESULTS: PPD (INTRADERMAL) ☐ NEG ☐ POS WHICH ARM? ☐ LT ☐ RT DATE READ_____

FOR MEDICAL DEPARTMENT USE ONLY REMARKS_____

	NORMAL	ABNORMAL	
GENERAL APPEARANCE			
SKIN			
NECK			
EYES			
EARS			
NOSE			
MOUTH			
TEETH			
THYROID			
LYMPH NODES			
CHESTAND LUNGS, BREAST			
MURMURS			
HEART			
ABDOMEN			
INGUINAL, INCLUDE HERNIAS			
SPINE			
FORWARD BEND FINGERS MISS FLOOR	INCHES		
UPPER EXTREMITIES			
HANDS			
LOWER EXTREMITIES			
GAIT			
VARICOSITIES			
FEET			
PERIPHERAL VASCULAR			
NEUROLOGIC INCLUDE REFLEXES			

COMMENTS – MEDICAL NOTES

MEDICAL EMPLOYMENT RECOMMENDATIONS

☐ ACCEPTABLE WITHOUT WORK LIMITATIONS

☐ ACCEPTABLE SUBJECT TO FOLLOWING WORK LIMITATIONS

☐ HOLD PENDING CORRECTION/CONTROL OF

☐ PATIENT SHOULD CONSULT PRIVATE PHYSICIAN REGARDING THE FOLLOWING

☐ NOT ACCEPTABLE BECAUSE

DATE _____ PHYSICIAN'S NAME _____
(PRINT)

_____
(SIGNATURE)

NAME OF CLINIC _____

PHYSICAL EXAMINATION

MEDICAL AUTHORIZATION & CONSENT: I HEREBY CERTIFY THAT ALL STATEMENTS ON THIS FORM AND FOLDER ARE TRUE AND THAT I AM NOT SUFFERING FROM ANY INJURY OR CHRONIC DISEASE EXCEPT AS STATED. (FALSIFICATION OF THE ABOVE IS CONSIDERED SUFFICIENT CAUSE FOR TERMINATION.) THE EXAMINING FACILITY IS AUTHORIZED BY ME TO RELEASE THE CONTENTS AND FINDINGS OF THIS EXAMINIATION TO THE ABOVE NAMED EMPLOYER. I UNDERSTAND THAT THIS IS NOT AN EXTENSIVE PHYSICAL EXAMINATION AND THAT IT IS MY RESPONSIBILITY TO SEEK MEDICAL COUNSEL FOR ANY CONDITIONS WHICH ARISE FROM THIS LIMITED EXAMINATION.

DATE _____ APPLICANT'S SIGNATURE _____

WITNESS _____