



Physical Examination Form

ALL OPERATOR PROGRAMS

Please type or print neatly.

NAME	LAST	FIRST	MIDDLE	LAST
SOCIAL SECURITY # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
DATE OF EXAMINATION: <input type="text"/> <input type="text"/> <input type="text"/>				
MAILING ADDRESS				PHONE
CITY				STATE ZIP

HEALTH HISTORY

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder
<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	Exhausted use	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease, or injury
<input type="checkbox"/>	<input type="checkbox"/>	Fluematous fever	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use			
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drug	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal			

If answer to any of the above is YES, PLEASE EXPLAIN

GENERAL APPEARANCE AND DEVELOPMENT:

	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
VISION:	For distance	<input type="checkbox"/> Right/20	<input type="checkbox"/> Left/20
		<input type="checkbox"/> Both/20	<input type="checkbox"/> Without corrective lenses
			<input type="checkbox"/> With corrective lenses
	Evidence of disease or injury:	Right _____	Left _____
	Color test:	Right _____	Left _____
	Horizontal field of vision:	Right _____	Left _____

HEARING: Right ear _____ Left ear _____

Evidence of disease or injury: Right ear _____ Left ear _____

AUDIOMETRIC TEST: ☐ 500 HZ ☐ 1000 HZ ☐ 2000 HZ ☐ 3000 HZ ☐ 4000 HZ
☐ 5000 HZ ☐ 6000 HZ ☐ 7000 HZ ☐ 8000 HZ

THROAT: _____

THORAX: Heart: _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after _____

Lungs: _____

ABDOMEN: Scars _____ Abdominal masses _____ Tenderness _____

Generic Physical Exam Form

**Thomas C. Rosenthal, Mark E.
Williams, Bruce J. Naughton**



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Table of Contents Generic Physical Exam Form

1. Understanding the eBook Generic Physical Exam Form
 - The Rise of Digital Reading Generic Physical Exam Form
 - Advantages of eBooks Over Traditional Books
2. Identifying Generic Physical Exam Form
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Generic Physical Exam Form
 - User-Friendly Interface
4. Exploring eBook Recommendations from Generic Physical Exam Form
 - Personalized Recommendations
 - Generic Physical Exam Form User Reviews and Ratings
 - Generic Physical Exam Form and Bestseller Lists

5. Accessing Generic Physical Exam Form Free and Paid eBooks
 - Generic Physical Exam Form Public Domain eBooks
 - Generic Physical Exam Form eBook Subscription Services
 - Generic Physical Exam Form Budget-Friendly Options
6. Navigating Generic Physical Exam Form eBook Formats
 - ePub, PDF, MOBI, and More
 - Generic Physical Exam Form Compatibility with Devices
 - Generic Physical Exam Form Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Generic Physical Exam Form
 - Highlighting and Note-Taking Generic Physical Exam Form
 - Interactive Elements Generic Physical Exam Form
8. Staying Engaged with Generic Physical Exam Form
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Generic Physical Exam Form
9. Balancing eBooks and Physical Books Generic Physical Exam Form
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Generic Physical Exam Form
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Generic Physical Exam Form
 - Setting Reading Goals Generic Physical Exam Form
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Generic Physical Exam Form
 - Fact-Checking eBook Content of Generic Physical Exam Form
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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