PHYSICAL EXAMINATION FORM

DATE OF EXAMINATION (Month / Day / Year) / /

TO BE FILLED IN BY EXAMINING PHYSICIAN (Please print)

OPERATOR'S NAME First Middle Last

SOCIAL SECURITY # | | | | | | | | | |

DATE OF BIRTH (Month / Day / Year) / /

AGE

HOME ADDRESS

PHONE

CITY

STATE

ZIP

HEALTH HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Muscular Disease	☐	☐	Head or spinal injuries
☐	☐	Kidney	☐	☐	Psychiatric Disorder	☐	☐	Seizures, fits, convulsions or fainting
☐	☐	Tuberculosis	☐	☐	Cardiovascular Disease	☐	☐	Extensive confinement by illness or injury
☐	☐	Diabetes	☐	☐	Gastrointestinal Ulcer	☐	☐	Any other nervous disorder
☐	☐	Nervous Stomach	☐	☐	Ethanol use	☐	☐	Suffering from any other disorder
☐	☐	Rheumatic Fever	☐	☐	Rx drug use	☐	☐	Permanent defect from illness, disease or injury
☐	☐	Over the counter drug use						

IF ANSWER TO ANY OF THE ABOVE IS YES, EXPLAIN:

GENERAL APPEARANCE AND DEVELOPMENT: ☐ Good ☐ Fair ☐ Poor

VISION: For Distance: ☐ Right/20 ☐ Left/20 ☐ Both/20 ☐ Without Corrective Lenses ☐ With Corrective Lenses

Evidence of disease or injury: Right Left

Color Test:

Horizontal Field of Vision: Right Left

HEARING: Right Ear Left ear

Evidence of disease or injury: Right Left

AUDIOMETRIC TEST: Decibel loss at ☐ 500 HZ ☐ 1,000 Hz ☐ 2,000 Hz ☐ 3,000 Hz ☐ 4,000 Hz ☐ 5,000 Hz ☐ 6,000 Hz ☐ 7,000 Hz ☐ 8,000 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

PHYSICAL EXAMINATION FORM ([redacted])

HERNIA: ☐ Yes ☐ No If so, where? _____ Is truss worn? _____

GASTROINTESTINAL: Ulceration or other disease? Yes _____ No _____

GENITO-URINARY: Scars: _____ Urinal Discharge: _____

REFLEXES: Rhomberg _____

Pupillary: _____ Light R _____ L _____

Accommodation: _____ R _____ L _____

KNEE JERKS: Right Normal _____ Increased _____ Absent _____

Left Normal _____ Increased _____ Absent _____

REMARKS: _____

EXTREMITIES: Upper _____ Lower _____ Spine _____

LABORATORY & OTHER SPECIAL FINDINGS: Urine Spec. Gr. _____ Alb. _____ Sugar _____

Other Laboratory Data (Serology, etc.) _____

Radiological Data _____ Electrocardiograph _____

GENERAL COMMENTS: _____

NAME OF EXAMINING DOCTOR (PLEASE PRINT) | SIGNATURE

ADDRESS OF EXAMINING DOCTOR

CITY | STATE | ZIP

MEDICAL EXAMINER'S CERTIFICATE TO BE COMPLETED ONLY IF OPERATOR IS FOUND QUALIFIED

MEDICAL EXAMINER'S CERTIFICATE
I certify that I have examined

CRANE OPERATOR'S NAME (PRINT)
with the knowledge of his/her duties,
I find him/her qualified under the regulations.

☐ Qualified only when wearing corrective lenses.
☐ Qualified only when wearing a hearing aid.
☐ Qualified — see Accommodation Statement attached.

A complete examination form for this person is on file in my office:

ADDRESS

DATE OF EXAMINATION | NAME OF EXAMINING DOCTOR

SIGNATURE OF EXAMINING DOCTOR

SIGNATURE OF OPERATOR

ADDRESS OF OPERATOR

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