Kaweah Delta
HEALTH CARE DISTRICT

EMPLOYEE HEALTH SERVICE- 559/624-2458
POST-OFFER/PRE-PLACEMENT PHYSICAL EVALUATION

**Health History**

Name_____ SSN _____-_____-_____Phone_____
Address_____City_____Zip_____
Birth Date (MM/DD/YYYY) _____Department_____Position_____
Family Physician_____

**Physical Requirements- Please Review Physical Demands and Job Description:**

1. Can you meet the essential functions/physical demands of your position with or without reasonable accommodation? ☐ Yes ☐ No
2. Have you ever had a work-related injury or illness that would prevent you from meeting the physical requirements of this job? ☐ Yes ☐ No
3. Do you have any physical restrictions? ☐ Yes ☐ No
4. Are you presently under a doctor's care for any condition related to your position? ☐ Yes ☐ No
5. Have you ever been hospitalized for any condition related to your position? ☐ Yes ☐ No

Please provide details for all "Yes" answers given above in items 1-5.

_____
_____
_____
_____

**Do you have any problems with the following related to the position? (Check "Yes" or "No")**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| 1. Vision | ☐ | ☐ | 9. Shoulder pain/injury | ☐ | ☐ | 16. Foot Pain/Injury | ☐ | ☐ |
| 2. Hearing | ☐ | ☐ | 10. Skin problems | ☐ | ☐ | 17. Ankle Pain/injury | ☐ | ☐ |
| 3. Yellow Jaundice or Hepatitis | ☐ | ☐ | 11. Chronic rash | ☐ | ☐ | 18. Knee Pain/Injury | ☐ | ☐ |
| 4. Hand/Wrist pain | ☐ | ☐ | 12. Hernia | ☐ | ☐ | 19. Broken Bones | ☐ | ☐ |
| 5. Neck injuries/problems | ☐ | ☐ | 13. Low back pain/Injury | ☐ | ☐ | 20. Restrictions on driver's License | ☐ | ☐ |

**Have you ever had an allergy or reaction to the following? (Check "Yes" or "No")**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Allergy to Latex | ☐ | ☐ | 4. Allergy to Foam pillows | ☐ | ☐ |
| 2. Allergy to Rubber gloves | ☐ | ☐ | 5. Any other allergic reaction, sensitivity or rash related to the position | ☐ | ☐ |
| 3. Allergy to bandages | ☐ | ☐ | | | |

_____
_____

**Immunization History:** ***Please complete and bring any immunization records.***

| Type | Vaccination Date |
|---|---|
| Rubella | |
| MMR | |
| Rubeola | |
| Mumps | |
| Varicella | |
| Tetanus Toxoid | |
| Hepatitis B | |

**Tuberculosis History:** ***For individuals with PPD reactor- please bring a copy of the X-ray report if done within the last 12 months.***

| Type (please circle one) | Date/s Given within the last 12 months | Date/s Read | Results |
|---|---|---|---|
| PPD/TB (within the last year)<br>or<br><br>Chest X-ray - if PPD positive | | | |
| If reactor, was treatment received? ☐ Yes ☐ No ☐ N/A | | | |
| If yes type of treatment received: | | | |
| TB Vaccine (BCG ) recipient? ☐ Yes ☐ No ☐ N/A Country: | | | |

*I certify that the above answers are true, and hereby give the examining practitioner permission to submit a report of my physical condition to Kaweah Delta Health Care District.*

*Signature*_____ *Date*_____