SUPERIOR FAMILY MEDICAL CENTER
525 EAST 11TH STREET
PO BOX 407
SUPERIOR, NE 68978

PHYSICAL EXAMINATION FORM

Employer/School: ____________________

PLEASE RETURN THIS FORM TO YOUR EMPLOYER / SCHOOL AFTER IT HAS BEEN COMPLETED BY YOUR FAMILY PHYSICIAN.

NAME: ____________________ S.S.#: ________________ BIRTH DATE: ________________

ADDRESS: ____

Allergies: ____

	Normal	Abnormal-Describe
Skin		
Head		
Eye Grounds		
Ears		
Mouth & Throat		
Scalp		
Neck		
Thyroid		
Lymph Nodes		
Heart		
Lungs		
Abdomen		
Genitalia (inc. hernia)		
Back and Spine		
Extremities		
Neurological		
Psychiatric		
Epilepsy		
Diabetes		

Immunizations:	Date				
Hepatitis					
Tetanus					
Measles					
Mumps					
Rubella					

(Any additional lab work or x-rays will be at the expense of the prospective employee.)

TB Skin Test ____________
Urinalysis ____________
Hemoglobin (Optional) ____________
Blood Pressure ________ Pulse ________
Height ____________
Weight ____________
Significant Past Illness or Injury ________

Any contraindications to the receipt of any required vaccine: ____________________

Any special or unusual condition? ____________________

Current Medications: (list) ____________________

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Physician Comments: ____________________

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"I certify that I have on this date examined this patient and that on the basis of the examination requested by the employer/school and the patient's medical history as furnished to me, I have found no reason which would make it medically inadvisable for this patient to be employed/participate at ____________________."

____________________ Date of Examination

____________________ Examining Physician's Signature

____________________ Date

____________________ Applicant's Signature