OSWEGO HOSPITAL

MEDICAL RECORD TO BE COMPLETED

Department _NEW VISIONS____

Name____Sex/ M___ F___

Address____________________________________Date of Birth ______Age__________

Phone Number_____________________

Physician/Address____

____

Are you now taking any medicine, prescription or over the counter (Pills, Tablets, Liquids) or injections? **Y** **N**

If yes, list name of medication, dosage, frequency and why you are taking it:

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____

Do you use alternate medicines/home remedies (herbal or other)? **Y** **N** If so, list

____

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Give the date of your last physical examination: _____________________________________

Do you have any health impairment which is a potential risk to other employees or which might interfere with the performance of your duties, including the over-use or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter your behavior? Y N

If yes, please explain:____

____

ALL APPLICANTS

Are you currently under the care of a physician now for any condition which would pose a direct threat to your own health or safety or the health or safety of any patients or co-workers (i.e any communicable disease, lifting restrictions, etc.) Y N _____________________________________

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Have you ever been injured on the job which required medical treatment? **Y** **N**

If so, list when, employer, nature of injury, and any resulting in restrictions: ____________________

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FAMILY HISTORY

Have any of your relatives ever had or do they now have the following:

(Please indicate yes or n and give relationship to you in the space provided).

Tuberculosis	Y	N	Food/drug allergies	Y	N
Hypertension	Y	N	Cancer	Y	N (if yes, what type)____________
Diabetes	Y	N			

PERSONAL HISTORY

Have you ever had or do you now have any of the following: Check if yes.

( ) DIABETES
( ) HEPATITIS
( ) HEMOPHILIA/EASY BLEEDING
( ) BLOOD DISEASE / CLOTS
( ) HIGH/LOW BLOOD PRESSURE
( ) STROKE
( ) COUGHING/SPITTING BLOOD
( ) BLOOD/PUS/SUGAR IN URINE
( ) CHEST PAIN
( ) HEART MURMUR
( ) POUNDING IN CHEST
( ) INFECTIOUS MONONUCLEOSIS

( ) BACK PROBLEMS
( ) PAINFUL JOINTS
( ) TRICK/LOCKED KNEE
( ) FRACTURES /DISLOCATIONS
( ) HOSPITALIZATIONS OTHER THAN CHILDBIRTH
( ) DEPRESSION/ANXIETY

( ) TUBERCULOSIS
( ) CHRONIC/FREQUENT ILLNESS; ASTHMA
( ) FAINTING SPELLS / DIZZINESS
( ) SEIZURES / CONVULSIONS
( ) EPILEPSY
( ) HEADACHES
( ) ALLERGY TO FOOD/DRUGS
( ) RUPTURE (HERNIA)
( ) THYROID TROUBLE
( ) ULCERS
( ) FREQUENT BLOODY BOWEL MOVEMENTS
( ) EYE DISEASE
( ) SKIN DISEASE
( ) LATEX ALLERGY
( ) SURGERY
( ) HEAD INJURY/CONCUSSION
( ) CANCER

( ) SMOKER would you like information about smoking cessation? ( )yes ( )no

If you have checked any of the above, please explain:

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____
____
____
____

I certify that the information given above is true to the best of my knowledge. I understand that any discovery of false or misleading information would be grounds for dismissal. I further understand that the offer of employment I received is contingent on successfully completing this physical examination. I further understand that ownership of this information belongs to Oswego Hospital.

Signature: ____ Date: ____________________

Reviewed by : ______________________________________ Date: ____________________