141 Roadrunner Parkway Ste 224
Las Cruces, NM 88011
PH: 575-524-8888 · F: 575-524-8132

Physical Examination

Date of Service:

Name:		Date of Birth:	
Employer:			

Height		Weight		Pulse Ox		Whisper Test	
Temperature		Pulse		BMI		Right	
Blood Pressure		Repeat BP				Left	

Vision Test

Uncorrected					Corrected		
Near	R: 20/	L: 20/		B: 20/	R: 20/	L: 20/	B: 20/
Distant	R: 20/	L: 20/		B: 20/	R: 20/	L: 20/	B: 20/
Visual Fields	Right:		Left:		Color:	☐ Normal	☐ Abnormal
Depth Perception		Sec of Arc			Ishihara:	/14	

	Normal	Abnormal		Normal	Abnormal
HEENT	☐	☐	Abdomen *Soft, NT, & Bruit*	☐	☐
Neck	☐	☐	Hernia *Direct/Indirect*	☐	☐
Thyroid	☐	☐	Musculoskeletal *ROM all extremities, 5/5 strength, & tone*	☐	☐
Lungs	☐	☐	Neurological *Sensation intact, CN 2-12, 2+ DTR*	☐	☐
Heart *Rhythm, Rate, & Sound*	☐	☐	Skin	☐	☐

Findings:

____

Urinalysis	SG:	Glucose:	Blood:	Protein:	
EKG	Normal	Abnormal	Findings:		
HPE	Normal	Abnormal	Comments:		
Audiogram	Normal	Abnormal	See Results		
Pulmonary Function Test	FEV1:	FVC:	FEV1/FVC:	☐ Normal	☐ Abnormal
Respirator Qualified	Yes ☐	No ☐	Comments:		

Examination Results:

☐ Able to perform essential functions without any restrictions.

☐ Following medical restrictions/findings are as follows: ______________________________________

Date: _________Provider: ______________________________Signature: __________________________________

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Name:		**Date of Birth:**	
Employer:			

Impairment History: (Historia de Impedimentos)

Do you have? (usted tiene)

Y N Loss of vision in either eye that cannot be corrected? (Perdida de la vista en en cualquier ojo, y no se corregida)
Y N Loss of hearing that requires a hearing aid? (Perdida del oido requiera del uso de un dispositivio auditivo)
Y N Decreased function in either hand? (Disminucion en el uso de sus manos)
Y N Decreased function in neck or lower back? (Disminucion en el moviemiento de cuello o de su espalda?)
Y N Decreased function in hips, knees, legs, ankles, or feet?
Disminucion en el moviemento de cadera, rodillas, piernas, tobillos, o pies)

Do you have any impairments or problems that would interfere with your ability to:
(impedimento que interfiera con su habilidad para:)

Y N Work at heights (trabajar en alturas)
Y N Work around or operate dangerous machinery (Trabajar cerca de u operar maquinas peligrosas)
Y N Drive company vehichles on public highways (Manaejar vehiculos de la compania en carreteras publicas)
Y N Use a respirator (Usar de un respirador)

Review of Systems (Chequiando su Sistema)

Have you ever had or been told you had: (Ha tenido o le han dicho que tiene?)

Y N Asthma, emphysema, shortness of breath (asma, emfisema, falto de respiracion)
Y N Back pain (dolor de espalda)
Y N Carpal tunnel syndrome (syndrome de la muneca)
Y N Diabetes (diabetes)
Y N High blood pressure (alta presion)
Y N Epilepsy or other seizure disorders (epilepsia u otra alteracion del control)
Y N Hepatitis, cirrhosis, jaundice, or other liver disease (hepatits, cirrhosis, ictericia, o padecimiento del higado)
Y N Sleep disorders (padece algun problema para concillar el sueno)
Y N Surgery (cirugia)

The above answers are true and correct to the best of my knowledge and belief. I understand that falsification may be grounds for termination. This also authorize release of any medical information, concerning my past or present condition pertinent to my employment, by the physicians and staff administering this examination. (Las respuestas dadas por mi son verdades y que han sido contestadas al alncance de mi conocimiento falsificacion a cualesquiera de dichas preguntas podra resultar en despido de mi empleo. Por medio autorizo, a sus medicos y personal, para obtener informacion medica.

Patient Signature: (Firma de patiente)____Date: _______________________