

MEDICAL EXAMINATION REPORT To Be Completed by a Licensed Physician

INSTRUCTIONS TO EXAMINING PHYSICIAN: Please review Health Questionnaire before examining the candidate. Do not forward this report until lab results are received. Use Section 24 for explanation of details, if necessary.

1. Name (Last, First, Middle) _____		2. Birth Date (Mo., Day, Yr.) _____	
3. Height (without shoes)	4. Weight (without shoes and coat)	5. Chest Girth (Expiration)	6. Abdomen Girth
8. Visual Acuity (if applicant wears glasses, test and record acuity both with and without glasses)			
a. Color Discrimination _____		b. Depth Perception _____	
c. Peripheral Vision (temporal) Right Eye _____ degrees		Left Eye _____ degrees	
(Each eye on zero line)			
d. Visual Acuity (16 inches) without glasses		R-20 / _____	L-20/ _____
(16 inches) with glasses		R-20/ _____	L-20/ _____
(20 feet) without glasses		R-20/ _____	L-20/ _____
(20 feet) with glasses		R-20/ _____	L-20/ _____
e. Eye fundus - findings _____			
f. Does examination reveal any internal or external eye pathology? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If Yes, describe: _____			
g. Is there any apparent eye deviation? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Note any eye or visual abnormality _____			

9. HEARING (Whispered conversation at 15 ft. considered normal)			
Right 15/ _____		HEARING AID USED	
Left 15/ _____		<input type="checkbox"/> No <input type="checkbox"/> Yes	
		DRUM PERFORATION OR DRAINAGE	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
NOTE ANY ABNORMALITY:			
9. Head (Note any defect, disease, or injury involving eyes, ears, nose, mouth, throat)			10. Dentistry Recommended
			<input type="checkbox"/> No <input type="checkbox"/> Yes
12. Lungs	13. Date Chest X-ray taken	13. Chest X-ray Normal	
		<input type="checkbox"/> No <input type="checkbox"/> Yes	
(report may be attached)			
14. CARDIO VASCULAR SYSTEM			
TYPE OF ACTION	BLOOD PRESSURE	PULSE RATE	SOUNDS
A. AT REST	/		
B. AFTER MODERATE EXERCISE			
C. TWO MINUTES AFTER EXERCISE	/		
D. CIRCULATION TO EXTREMITIES		E. NOTE ANY ABNORMALITY	
15. NERVOUS SYSTEM (Describe any Pathology or Abnormal Reflexes)			
16. ABDOMEN		17. RECTAL	
MASSES		FISSURE	
TENDERNESS		FISTULA	
HERNIA		HEMORRHOIDS	
18. GENITO-URINARY SYSTEM (Note any abnormalities)			

