Name		DOB	

NON DOT PHYSICAL EXAM

CHECK IF YOU HAVE HAD OR CURRENTLY HAVE THE FOLLOWING:	NOTES – ADDITIONAL HISTORY:
Blood Disorders, Blood Clots Anxiety, Panic Attacks Depression, Bipolar, Nervous Breakdown Asthma, Chronic Bronchitis, COPD Emphysema, Chronic Cough, Pneumonia Back Pain, Herniated disks Bowel or Colon or Stomach Problems Heart problems, Irregular rhythm, Valve Replacement Heart Attack, Pacemaker, Stent, High cholesterol Diabetes (Type I or Type II) Previous drug or alcohol abuse Unexplained dizziness or fainting Head trauma, concussion, head injury Hepatitis, HIV or other communicable diseases (STD) High Blood Pressure Migraines, Severe headaches Kidney disease, stones Liver problems, Pancreatitis Muscle problems, joint problems, Arthritis or Gout Gallbladder Problems Seizures (Epilepsy) Skin Problems Sleep Problems, Sleep Apnea Stroke Thyroid Problems (High or low) Urinary Problems Cancer Other:______________________________	☐ **No history of any medical conditions** **Do you:** **Smoke:** ☐ **Yes** ☐ **No** If yes, how much? ________ For how long? ___________ **(DIP/Chew)Smokeless Tobacco:** ☐ **Yes** ☐ **No** If yes, how much? ________ For how long? ___________ **Alcohol:** ☐ **Yes** ☐ **No** If yes, how much? ________ For how long? ___________ **Have Allergies:** ☐ **Yes** ☐ **No** If yes, Describe:____________ ___________________________ **Take any medications/vitamins?** ☐ **Yes** ☐ **No**

LIST PRESCRIBED MEDICATIONS – SUPPLEMENTS – OVER THE COUNTER: DOSAGE – ROUTE-HOW OFTEN		LIST ANY SURGERY, HOSPITALIZATIONS, OR ANY PROCEDURES: DATES & DOCTOR
1.		
2.		
3.		

VERIFICATION	
I have read and filled out the above health information to the best of my knowledge and declare that I have had no injury or ailment other than specifically noted. Any falsification or misrepresentation will be sufficient grounds to revoke Provider's Written Opinion for employment or release.	
Patient Signature:	Date:

1111 Scurry Street * Big Spring, Texas 79720 * Phone 432.264.1920 * Fax 432.264.1725 *
www.wtip.biz