Bayhealth

1275 S. State Street, Dover, DE 19901
phone (302) 678-1303 fax (302)736-4332

301 Jefferson Avenue, Milford, DE 19963
phone (302) 430-5705 fax (302)430-5679

632 Mulberry St, Milton, DE 19968
phone (302) 684-3812 fax (302) 684-2012

Patient Label

GENERIC PHYSICAL

Date:____/____/____ **Name:**_____ **Sex:** M ☐ F ☐

Street Address:_____

City:_____ **State:**_____ **Zip:** _____

Current Occupation: _____ **Job Description:** _____

Phone Number: (_____) _____-_____ **Family Physician**:_____

Allergies (please list):_____

_____

Current medications (include herbal remedies): _____

_____

_____

YOUR MEDICAL HISTORY:

Do you have now or ever had any of the following?	NO	YES	Do you have now or ever had any of the following?	NO	YES
Back injury and/or problem	☐	☐	High blood pressure	☐	☐
Bedridden due to injury	☐	☐	Loss of memory	☐	☐
Been hospitalized (provide date(s):_____)	☐	☐	Major joint surgery	☐	☐
Blood in stool or urine	☐	☐	Neck and/or back surgery	☐	☐
Broken bone	☐	☐	Received a blood transfusion	☐	☐
Chest pain	☐	☐	Ringing in ears	☐	☐
Current health concern	☐	☐	Seizure	☐	☐
Depression and/or anxiety	☐	☐	Shortness of breath	☐	☐
Diabetes	☐	☐	Smoke and /or smokeless tobacco use: provide # yrs_____	☐	☐
Dizziness, lightheadedness, and/or fainting	☐	☐	Stroke	☐	☐
Emphysema and/or chronic cough	☐	☐	Torn muscle and/or severe strain or sprain	☐	☐
Frequent heartburn and/or stomach pain	☐	☐	Toxic exposure (dust, fumes, etc.)	☐	☐
Gallbladder disease	☐	☐	Tuberculosis	☐	☐
Gout, bursitis, or arthritis	☐	☐	Ulcer	☐	☐
Head injury	☐	☐	Yellow jaundice and/or Hepatitis	☐	☐
Heart murmur	☐	☐	Other medical condition:_____	☐	☐

Briefly explain "yes" answers: _____

_____

I attest that the above is a true and full disclosure of my past medical history.

Patient Signature: _____ **Date:**____/_____/___ **Time:**_____

****

Provider's comments: (*Comment on any positive answers above*)

_____

_____

Provider's Signature: _____ **Date:**____/_____/___ **Time**:_____

Barcode

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Patient Label

GENERIC PHYSICAL

Type of Exam:	General:
□ Pre-employment	Weight:_____ kg
□ Annual	Height: _____ in.
□ Fit for duty	Pulse:_____
□ School	Blood pressure:_____/_____
□ Other:_____	Temperature:_____

Audiogram:				
Right ear:	500: _____db	1000: _____db	2000:_____db	4000:_____ db
Left ear:	500: _____db	1000: _____db	2000:_____db	4000:_____ db

Color Vision				Visual Acuity (uncorrected)		
Right:	_____	Left:	_____	OD:_____	OS:_____	OU:_____
Peripheral Vision				**Visual Acuity (corrected)**		
Right:	_____	Left:	_____	OD:_____	OS:_____	OU:_____

Urinalysis												
Void	Turbid	Color	Leuk	Nitrate	Urobili	Prot	pH	Blood	Sp. Grav	Ketone	Bili	Gluc
CC	Clear											
Cath	Hazy											

Nurse/Tech Signature:_____ **Date:**_____/_____/_____ **Time:** _____ **AM / PM**

Nurse/Tech Comments:

_____

_____

_____

_____

_____

Provider's Signature:_____ **Date:**_____/_____/_____ **Time:** _____ **AM / PM**