HISTORY FORM

St. Joseph's/Candler Immediate Care | South Georgia Immediate Care Center

YOUR IMMEDIATE CARE CENTERS from GEORGIA EMERGENCY ASSOCIATES

Date of Exam_____

Name_____ Date of Birth_____

Sex ( ) Male ( ) Female Age_____

Are you allergic to any medications? If yes please list the reaction along with it:_____

_____

_____

Other allergies? ( )Pollens ( )Foods ( )Insect stings Explain:_____

Please list any medications that you take:

Please mark "yes" or "No" to the questions that apply to you.
Have you ever had or have any of the following?

	YES	NO		YES	NO
Anemia			Hearing problems		
Asthma			Heart problems		
Back problems			Hernia		
Musculoskeletal			High blood pressure		
Bleeding tendencies			Hives or rashes		
Bronchitis			Kidney/Bladder trouble		
Cancer/tumor			Liver disease/hepatitis		
Diabetes			Lung disease		
Bowel/Stomach problems			Mononucleosis		
Emphysema			Pneumonia		
Epilepsy			Rheumatic fever		
Eye problems			Rheumatism/Arthritis		
Fever			Skin disorders		
Mental disorders					

·Have you had any work-related injuries or illnesses? ( ) Yes ( ) No. If yes, explain

_____

·Immunization/infectious disease history:

Please mark those infections/immunizations you ever had.

( ) Measles ( ) German Measles ( ) Mumps ( ) Chicken Pox ( ) Polio

·Have you ever had a tuberculosis skin test? ( ) Yes ( ) No

·Was there a reaction requiring a chest x-ray? ( ) Yes ( ) No

·Have you ever been turned down for life insurance, military service or employment because of health problems? ( ) Yes ( ) No If yes, explain

_____

_____

·Current health status: Please check next to any and all of the following that apply to you.

( ) Never smoked ( ) Smoking currently ( ) Stopped smoking _____years ago

( ) Alcohol consumption _____Daily _____Weekly _____Never

( ) Drug use ( ) Cough ( ) Eye/Vision problems ( ) Hearing problems ( ) Shortness of breath ( ) Frequent headaches

·Do you wear glasses? ( ) Yes ( ) No Contact lenses? ( ) Yes ( ) No

·Do you have any mental disorders? ( )Yes ( ) No If yes, explain

_____

·Are you able to independently bend and lift up to 25lbs repetitively without any restrictions? ( ) Yes ( ) No

I testify that the information which I have given is accurate and complete.

_____ Date _____

Signature

PHYSICAL EXAMINATION FORM

St. Joseph's/Candler Immediate Care | South Georgia Immediate Care Center

YOUR IMMEDIATE CARE CENTERS™ from GEORGIA EMERGENCY ASSOCIATES

Name_____ Date of Birth_____

EXAMINATION		
Height (in) Weight ( )Male ( ) Female		
BP / (/) Pulse Vision: R 20/ L20/ Bilateral 20/ Corrected Yes( ) No( )		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance *Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span >height,hyperlaxity,myopia,MVP,aortic insufficiency)		
Eyes/Ears/Nose/Throat • Pupils equal • Hearing		
Lymph Nodes		
Heart • Murmurs (auscultation standing, supine,+/- Valsalva) • Location of point of maximal impulse (PM)		
Pulses • Simultaneous femoral & radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
Functional • Heel toe, single leg hop		

( ) Cleared for work (volunteer) without restrictions.

( ) Cleared for all work (volunteer) without restriction with recommendations for further evaluation or treatment for_____

_____

( ) Not cleared

( ) Pending further evaluation

( ) For any work (volunteer)

( ) For certain work (volunteer) _____

Reason_____

Recommendations_____

_____

LABORATORY

URINE:

Specific Gravity _____

Albumin _____

Glucose _____

Blood _____

I have examined the above-named and completed the preparticipation physical evaluation. The worker/volunteer does not present apparent clinical contraindications to practice and participate in the work/volunteer environment as outline above. A copy of the physical exam is on record in my office and can be made available to the work/volunteer facility at the request. If conditions arise after the work/volunteer has been cleared for work/participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the work/volunteer.

Name of Physician (print/type)_____ **Date**_____

Signature of physician_____, **M.D, D.O, P.A, N.P**

CLEARANCE FORM

St. Joseph's/Candler Immediate Care | South Georgia Immediate Care Center

YOUR IMMEDIATE CARE CENTERS from GEORGIA EMERGENCY ASSOCIATES

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all employment activities without restriction.

☐ Cleared for all employment activities without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any employment activities
- ☐ For certain employment activities _____

Reason _____

Recommendations _____

_____

_____

_____

_____

_____

I have examined the above-named individual and completed the physical examination. The individual does not present apparent clinical contraindications to practice and participate in the activities as outlined above. A copy of the physical exam is on record in my office and can be made available at the request of the above-named individual. If conditions arise ater the employee has been cleared, the physician may rescind the clearance until the problem is resolved and potential consequences are completely explained to the above-named individual.

Name of physician (print/type) _____ Date _____

Address _____ Phone 9124501945

Signature of physician _____ MD or DO

St. Joseph's/Candler Immediate Care
107 Canal Street
Pooler, GA 31322
Ph: 912-450-1945 Fax: 912-450-1949

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____