☐ **Depew**
6199 Transit Road
Depew, N.Y. 14043
Phone: (716) 206-0390
Fax: (716) 206-0394

☐ **Southtowns**
1900 Ridge Road
West Seneca, N.Y. 14224
Phone: (716) 712-0670
Fax: (716) 712-0674

☐ **Ken-Ton**
2075 Sheridan Drive
Kenmore, NY 14223
Phone: (716) 447-6474
Fax: (716) 447-6433

PHYSICAL EXAMINATION

Name			Date	
Address	Birth Date		Age	Sex
City	State	Zip	Employer	

GENERAL HEALTH HISTORY

PLEASE PLACE AN "X" IN THE YES COLUMN FOR ANY CONDITION OR PROBLEM YOU HAVE NOW OR HAVE HAD IN THE PAST

	YES		YES		YES		YES
HEAD		**CARDIAC / RESPIRATORY**		**MUSCULAR / SKELETAL**		**GENERAL**	
Frequent Headaches		Asthma		Back Injury / Disc Problems		Any Cancer **NOT** Noted Previously	
Fainting		Emphysema (COPD)		Neck Injury / Disc Problems		Diabetes	
Head Injury		Chest Pain		Chronic Back Pain		Significant Sleep Problems	
Convulsions / Seizures		Heart Attack / Heart Disease		Chronic Neck Pain		Depression / Anxiety	
EYES		Heart Surgery		Shoulder Injury / Pain			
Wear Glasses / Contacts		Shortness of Breath		Elbow Injury / Pain		**MALES ONLY**	
Recent Vision Change		High Blood Pressure		Wrist Injury / Pain		Prostate Problems	
Color Blindness		Varicose Veins / Leg Ulcers		Hand Injury / Pain		Testicle Pain / Swelling	
Glaucoma		Phlebitis / Blood Clots in Legs		Hip Injury / Pain		Cancer of Testicle	
Retinal Detachment		Swelling of Ankles / Feet		Knee Injury / Pain		**FEMALES ONLY**	
EARS		Tuberculosis / "+" PPD Test		Ankle Injury / Pain		Breast Lumps	
Hearing Problems		**GASTROINTESTINAL**		Foot Injury / Pain		Breast Cancer	
Ringing in Ears		Stomach Ulcer		Broken Bones / Fractures		Hysterectomy	
Dizziness		Frequent Heartburn		Joint Replacement		Other "female" surgery	
NECK / THROAT		Weight Gain / Loss (Over 10 lbs.)					
Nose, Throat, Sinus Trouble		Hepatitis		**DERMATOLOGIC**		**GENITAL / URINARY**	
Thyroid Trouble		Hernia / Rupture		Skin Rash		Blood in Urine	
Neck Tumors		Gallstones / Gall Bladder Surgery		Skin Cancer		Kidney Stones	
Trouble Swallowing		Colitis		Skin Grafting		Other Kidney Problems	

Do you presently smoke?	YES☐ NO☐	How many packs per day? ½☐ 1☐ 1½☐ 2☐
If you currently don't smoke, did you ever smoke?	YES☐ NO☐	If YES, for how long did you smoke? ____________
If you have quit smoking, when did you quit?		
Do you drink any alcoholic beverages?	YES☐ NO☐	If YES: Daily☐ Weekends☐ Seldom☐
Do you have any disabilities or work restrictions?	YES☐ NO☐	Please provide the name of doctor who placed you on these restrictions in the comments section below.
Have you lost more than a week at work during the past 3 years due to illness or injury?	YES☐ NO☐	Please provide the details of why you were out of work in the comments section below.

Any prior significant exposures at work:								
	Chemicals	☐	Fumes / Gases	☐	Radiation	☐	Noise	☐
	High/Low Temperatures	☐	Asbestos	☐	Infectious Disease	☐	Heavy Lifting	☐

Please provide details of any YES answers: ____

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____

____

Allergies to medications or foods: ____________________ For Women Only: Date of last menstrual period ____________

I certify that my answers to the above questions are accurate, to the best of my knowledge.____________________
Patient Signature

DO NOT COMPLETE SECTION BELOW – FOR PROVIDER USE ONLY

Surgical History	Medications (Prescription & OTC)