Manatí Medical Center

# MEDICAL EVALUATION

NAME: _____ AGE: _____

| HEALTH HISTORY | | |
|---|---|---|
| Allergies (foods, drugs & environment) | ☐ No known allergies<br>☐ Yes, _____ | |
| Habits | ☐ smoking, amount per day: _____<br>☐ alcohol drinking, amount per week: _____<br>☐ caffeine drinking, amount per day: _____<br>☐ street drugs, type & amount per day: _____ | |
| Medicines currently taken | 1. _____<br>2. _____<br>3. _____<br>4. _____ | 5. _____<br>6. _____<br>7. _____<br>8. _____ |
| List of all serious illnesses, operations, and hospitalizations | ☐ None<br>1. _____<br>2. _____<br>3. _____<br>4. _____ | |

| Weight _____ Lb | Height _____ ft _____ in | BP | HR | RR | T |
|---|---|---|---|---|---|
| General appearance | ☐ Alert, active, oriented, no distress, adequate weight<br>☐ Other: _____ | | | | |

| REGION | NORMAL | ABNORMAL | DETAILS |
|---|---|---|---|
| Head | ☐ | ☐ | |
| Ears | ☐ | ☐ | |
| Nose | ☐ | ☐ | |
| Throat | ☐ | ☐ | |
| Neck | ☐ | ☐ | |
| Chest | ☐ | ☐ | |
| Heart | ☐ | ☐ | |
| Lungs | ☐ | ☐ | |
| Abdomen | ☐ | ☐ | |
| Legs | ☐ | ☐ | |
| Skin | ☐ | ☐ | |
| Neurologic | ☐ | ☐ | |
| Emotional/Psychiatric | ☐ | ☐ | |

After evaluating above described information, I hereby certify that _____ is able to work:

☐ WITHOUT ANY KIND OF RESTRICTIONS

☐ WITH RESTRICTIONS SPECIFIED AS FOLLOWS:

_____

_____

_____

☐ See reverse for more details

_____ _____ _____

EVALUATING PHYSICIAN'S SIGNATURE DATE LIC.

_____ _____

PRINT NAME PHONE