# New Employee Physical Exam Form

**Employee Information:**

**Full Name: _____**

**Position Applied For: _____**

**Employer Name: _____**

**Medical History:**

**☐ No Known Medical History**

**☐ Allergies (Specify): _____**

**☐ Chronic Conditions (Specify): _____**

**Physical Exam Results:**

**Height: _____**

**Weight: _____**

**Blood Pressure: _____**

**Vision: ☐ Normal ☐ Corrective Lenses Required**

**Workplace Capability Table:**

| Assessment Type | Results | Comments | Action Needed |
|---|---|---|---|
| Physical Fitness | | | |
| Hearing | | | |
| Vision | | | |
| Respiratory Function | | | |

**Doctor's Certification:**

**Physician's Name: _____**

**Signature: _____**

**Date: _____**