**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**