Autumn Medical Group

9200 Colima Rd. #207 :: Whittier, CA 90605 :: (562) 945-0252

Patient Name: _____D.O.B.: _____ Phone(___)_____-_____

Age: _____ Male [ ] Female [ ] Preferred Language: English Spanish Other:_____

Allergies to medications (and what happens if when taken) _____

Pharmacy Name_____Street Adress and City_____

Please list all Medications/Vitamins: Please include strength and frequency of dosages:

Please circle all that apply:

Past Medical History: Hypertension (High blood pressure), Diabetes Mellitus, Insulin Dependent Diabetes Mellitus, Stroke, Heart Attack, Congestive Heart Failure, Gout, Hyperthyroid, Hypothyroid, Asthma, COPD, Hepatitis, Pancreatitis, GERD, Lupus, Rheumatoid Arthritis, Osteoarthritis, Cancer, High Cholesterol, Kidney Disease, Dialysis, Depression or Mania, Gastritis, Seizures, Migraines

Other: _____

Past Surgical History: Gallbladder Removal, Appendix Removal, Thyroid Removal, Tonsillectomy, Hysterectomy, C-Section, CABG (open heart surgery), Hernia Repair, Angioplasty, Cancer Surgery, Hip replacement, Knee surgery

Other: _____ Year(s) of Surgery: _____

Social History:

Have you ever smoked? **Y/N** If yes, how many packs per day? ____ If yes, what year did you start?_____ When Quit?_____

Do you drink alcohol? **Y/N** If yes, how much do you drink? 1-3 4-6 7-9 9-12 per day/week/month

Social History: Circle One:

Single Married Separated Divorced Widowed. Are you living with your husband or wife?…….No Yes
Do you have children (dependents) at home?……..No Yes

Are you employed? Full time Part time Not employed Disability Retired

What kind of work do you do?_____What is your job title at work?_____

Are you exposed to fumes, toxins, or solvents?…No Yes (if yes what type) _____
Educational Level? (**circle number of years of each**)? High School 1,2,3,4, diploma College: AA. BA, BS
Postgraduate: M.A., M.S., MD, JD, MBA, Ph.D.

Family History: Do any family members have the following? Please place an X in the appropriate box if any of these apply.

	High Blood Pressure	Heart Attack	Stroke	Diabetes	Cancer (please list type)	High Cholesterol	Tuberculosis	Hemophilia
Mother								
Father								
Sister								
Brother								
	None of the above	None of the above	None of the above	None of the above	None of the above	None of the above	None of the above	None of the above

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Please circle all that apply to how you are feeling right now:

General: Fevers, Fatigue, Sweats, Chills**,**

Endocrine: Excessive Thirst, Weight Loss, Weight Gain

Heme: Unusual easy Bruising, Unusual Unstoppable Bleeding

Allergy/Immunology: Sinus Problems, Hay Fever (Allergic Rhinitis)

HENT: Sore Throat, Earache, Runny Nose (Rhinorrhea), Bruxism (teeth grinding)

Eyes: Red Eyes, Eye Discharge (Crusting), Double Vision (Diploplia)

Pulmonary: SOB (Dypsnea), Dry Cough (No Phlegm), Productive Cough, Wheezing

Heart: Palpitations (Irregular Heart Beat), High Blood Pressure, Rapid Heart Rate (Heart Racing)

GI: Nausea, Vomiting, Diarrhea, Abdominal Pain or Cramps, Heartburn

GU: Burning or Painful Urination (Dysuria), Blood in Urine (Hematuria),

GU: (Female patients) Pelvic or Genital Pain, Abnormal Vaginal Pain, Menstrual Pain, Vaginal Discharge

Musculoskeletal: Joint Pain, Muscle Pain

Neurology: Headache, Seizures, Vertigo (Room Spinning)

Psychiatry: Anxiety, Depressed or Sad

Skin: Rashes

Medications taken within the past six months:

Plavix, or Coumadin……..……...No Yes

Aspirin…(**NOT** Tylenol or Ibuprofen).……..No Yes

Sleeping pills……..……..……..No Yes

Gynecological: (females only)

Age periods started?_____

How long do periods last?_____

How many times have you been pregnant?_____

Number of Miscarriages?_____

When was your last PAP Smear _____

When was your last mammogram?_____

When was your last period? _____

As part of our continuing compliance with the Patient Protection and Affordable Care Act of March 23, 2010 there is some information that we require from you in order to update the patient information in our records.

RACE	Ethnicity	Preferred Language
☐ American Indian or Alaskan Native	☐ Hispanic	☐ English
☐ Asian	☐ Non-Hispanic	☐ Spanish
☐ Black	☐ Caucasian	☐ Hindi
☐ Caucasian		☐ French
☐ Other		☐ Chinese
☐ Pacific Islander		☐ Tagolog
☐ Declined		☐ Other

Have you ever used any of the following: No Yes (Circle items previously used)
Marijuana, Cocaine, Methamphetamines, LSD, PCP, Ecstasy, Speed, Heroin, Mushrooms

When was the last time you used?_____

_____ _____ _____

Patient's Signature Physician's Signature Date

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This evaluation is only to determine readiness for employment . It should not be used as a substitute for regular health maintenance examinations. A positive response to any of the following questions should be brought to the doctor's attention. Please circle the most appropriate answer.

1. Have you had a medical illness or injury that required you to visit a physician and miss FIVE or more consecutive days of work? ..... ***YES or NO***

2.
a. Have you passed out or been dizzy with exercise or work?..... ***YES or NO***
b. Have you had chest pain (or pressure) with exercise or work?..... ***YES or NO***
c. Have you had excessive unexplained shortness of breath or fatigue with exercise? ..... ***YES or NO***
d. Has someone in your family died, or had serious problems, from heart disease under the age of 50 years old ?..... ***YES or NO***

3. a. Have you had a head injury or concussion?..... ***YES or NO***
b. Have you been knocked out, become unconscious, or lost your memory?..... ***YES or NO***
c. Have you had a seizure?..... ***YES or NO***
d. Have you developed frequent or severe headaches?..... ***YES or NO***
e.Do you currently have numbness or tingling in your arms, hands, legs, or feet?..... ***YES or NO***

4. Have you become sick from exercising in the heat?..... ***YES or NO***

5 Have you developed a cough, wheeze, or have trouble breathing during or after activity?..... ***YES or NO***

6. Have you started requiring any special protective or corrective equipment or devices that aren't usually used for your position (for example, knee brace, special neck roll, foot orthotics, hearing aid)?..... ***YES or NO***

If yes please explain _____

7. Have you had any problems with your eyes or vision, **other than** requiring glasses or contacts?..... ***YES or NO***

8. Have you had any problems with sprains, dislocations, fractions, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you?..... ***YES or NO***

If yes, circle the appropriate item below.

Head	Elbow	Hip
Neck	Forearm	Thigh
Back	Wrist	Knee
Chest	Hand	Shin/Calf
Shoulder	Finger(s)	Ankle
Upper Arm	Foot	Toe(s)

9. Would you like to talk to a physician about your weight, about stress, anger, depression or any other issues?..... ***YES or NO***

10. Is there any reason you should be restricted from being employed at your applied position..... ***YES or NO***

11. Are you able to safely lift up to 50 pounds? ..... ***YES or NO***

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Patient_____ Signature of Parent/Guardian_____ Date_____

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Instructions on setting up your pre-employment physical

- Please call Autumn Medical Group at (562) 945-0252 and speak with the office scheduler and notify her that you are in need of a Whittier Hospital Pre-employment screening physical
- **Bring the following items with you when you come:**
  - Vaccine records
    - Infuenza vaccine (current season)
    - Measles, Mumps, Rubella: 2 documented doses spaced ≥28 days apart or titer showing immunity
    - Varicella: 2 documented doses spaced ≥28 days apart or titer showing immunity
    - Hepatitis B: Positive titer or declination form
    - Tdap: Vaccination on record within past 10 years or declination form
    - Influenza vaccine: Vaccination on record or declination form
    - TB clearance: 2 documented negative PPDs in the past year (one within the past 30 days)
      OR : Negative BAMT (Quantiferon) within the past 30 days

      OR : Negative symptom screen and negative chest xray
  - Medications and supplements that you are currently taking
  - Previous medical records that will assist the doctor in assessing your current state of health (if needed).
  - Please come fasting for 12 hours prior to the visit so your blood may be drawn. Please drink plenty of water the day before and day of the appointment.
  - Please complete the forms in this packet prior to arriving to you appointment.
- Expect 2 to 3 visits to complete all requirements: (2 if a negative PPD has been done in the last year, 3 if a 2 step PPD is needed)
  - Visit#1: Review of medical history and medical records review
    - Assessment of vaccine requirement
    - Blood draw
    - PPD placement
  - Visit #2
    - Comprehensive physical including
      - HEENT
      - CV
      - Pulm
      - M/S
      - Skin
      - Neuro
      - Vision test
      - Hearing test
    - N95 Mask fitting and PAPR training.
    - PPD read