BCRC
BE PART OF SOMETHING

PHYSICAL FORM

131 Pleasant Drive, 2nd Floor
Aliquippa, PA 15001
Phone: 724-378-4750
Fax: 724-378-4526

Name _____ Age _____

Address _____ Phone _____

PAST HOSPITALIZATIONS AND OPERATIONS

Date	Place	Reason

MEDICATIONS AND DOSAGES (Please indicate any special instructions)

_____

_____

_____

_____

Is the patient permitted to take the following at his/her request?

Aspirin Yes _____ No _____

Tylenol Yes _____ No _____

Antacids Yes _____ No _____

MEDICAL INFORMATION

Allergies _____ Lungs _____

Ano-Rectal _____ Nervous System _____

Back Problems _____ Obesity _____

Communicable Diseases _____ Orthopedic _____

Diabetes _____ Respiratory System _____

Elimination _____ Seizures _____

Eyes, Ears, Nose, Throat _____ Skin Condition _____

Gynecological (breasts, etc.) _____ Thyroid _____

Heart Conditions _____ Tonsils _____

Hernias _____ Tuberculosis _____

Inadequate Immunizations _____ Tumors _____

Diphtheria (Date) _____ Tetanus _____

Volume II of the Dictionary of Occupational Titles, pp. 654-655 published by the United States Department of Labor (3rd Edition, 1965) classifies five degrees of work in terms of strength required. To provide for the employee's health and safety, please check the degree of work you feel this patient is capable of performing.

A. Restrictions: _____ Yes _____ No

If yes, complete each of the following items in detail.

1. ( ) SEDENTARY WORK: Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

2. ( ) LIGHT WORK: Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree, or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

3. ( ) MEDIUM WORK: Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

4. ( ) HEAVY WORK: Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

5. ( ) VERY HEAVY WORK: Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

B. **In an 8 hour work day patient can stand/walk:**
( ) None ( ) 1-4 hours ( ) 3-5 hours ( ) 6-8 hours

C. **In a 9 hour work day patient can sit:**
( ) 1-3 hours ( ) 3-5 hours ( ) 5-8 hours

D. **Patient can use hands for repetitive:**
( ) Simple grasping ( ) Pushing and Pulling ( ) Fine Manipulation

E. **Patient can use feet for repetitive movement as in operating foot controls:**
( ) Yes ( ) No

F. **Patient is able to:**

	Frequently	Occasionally	Not at All
Bend	( )	( )	( )
Squat	( )	( )	( )
Climb	( )	( )	( )

Comments:

Date _____ Physicians Signature _____

Please specify and summarize any remarkable conditions or limitations: (also list any important medical information)

_____

_____

_____

Should the patient be limited in his/her activity in the working situation because of the medical conditions noted above? Yes _____ No _____ Please Specify: _____

_____

Does this patient follow any special programs (exercise, diet, etc.) _____

_____

HABITS

Alcohol ____ Drugs ____ Tea ____ Tobacco ____ Water ____ Coffee ____ Sleep ____

Other _____

PHYSICIAL EXAMINATION

Weight _____ Height _____ Blood Pressure _____ Pulse _____

Vision: Distance = R 20/ _____ L 20/ _____ With Glasses = R 20/ _____ L 20/ _____

Hearing: R 15/ ____ L 15/ ____ Tonsils: Normal _____Enlarged _____Removed _____

LABORATORY

Urinalysis: S.G. _____ Serology Indicated: Yes _____ No _____

Albumen _____ Pap Smear: Positive _____ Negative _____

Sugar _____

COMMENTS, IMPRESSIONS, AND RECOMMENDATIONS:

_____

_____

_____

_____

Physician _____ Phone _____

Address _____

Date _____ Physician's Signature _____