DATE: _____

COMPANY: _____

LAST NAME: _____ FIRST NAME: _____MI: _____

STREET ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

Birth Date: _____ Age: _____ SSI#: _____

BLOOD PRESSURE: SITTING: _____mmHg ARM: _____ TIME: _____

SECOND READING (OPTIONAL): _____mmHg ARM: _____ TIME: _____

OTHER TESTING IF INDICATED: _____

PULSE: _____ PULSE RHYTHM REGULAR: YES NO

HEIGHT: _____Feet _____Inches WEIGHT: _____Pounds. BMI: _____

URINALYSIS Sp. Gr.: _____ Blood: _____ Protein: _____ Sugar: _____

Protein, blood, or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

VISION: Standard is at least 20/40 acuity (Snellen) in each eye with or without correction. At least 70 degrees field of vision in horizontal meridian measured in each eye. The use of corrective lenses should be noted.

Acuity	Uncorrected	Corrected	Horizontal Field of Vision
Right Eye:	20/____	20/_____	Right Eye: _____degrees
Left Eye:	20/____	20/_____	Left Eye: _____degrees
Both Eyes:	20/____	20/_____	

	Yes	No
Applicant can recognize and distinguish among traffic control.	____	____
Signals and devices showing red, green, and amber colors	____	____
Monocular vision	____	____
Referred to ophthalmologist or optometrist?	____	____
Received documentation from Ophthalmologist or optometrist?	____	____

HEARING

Standard: Must first perceive whispered voice at not less than 5 feet OR average hearing loss of less than or equal to 40dB, in better ear (with or without hearing aid(s)).

Check if hearing aid used for test: ____Right Ear ____Left Ear ____Neither

Whisper Test Results	Right Ear	Left ear
Record distance (in feet) from person at which a forced Whispered voice can first be heard	_____	_____

OR

Audiometric Test Results

Right Ear			Left Ear		
500Hz	1000Hz	2000Hz	500Hz	1000Hz.	2000Hz
_____	_____	_____	_____	_____	_____

Average Right Ear: _____ Average Left Ear: _____

PHYSICAL EXAMINATION

The presence of a certain condition may not necessarily disqualify a person, particularly if the condition is controlled adequately, is not likely to worsen, or is readily amenable to treatment. Even is a condition does not disqualify a person, the Medical Examiner may consider deferring the person temporarily. Also, the person should be advised to take the necessary steps to correct the condition as soon as possible, particularly is neglecting the condition could result in a more serious illness that might affect work.

Check the Body Systems for Abnormalities.	**Normal**	**Abnormal**
Body System General Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	_____	_____
Eyes Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos. Ask about retinopathy, cataracts, aphakia, glaucoma, macular degeneration and refer to a specialist if appropriate.	_____	_____
Ears Middle ear disease, occlusion of external canal, perforated eardrums.	_____	_____
Mouth & Throat Irremediable deformities likely to interfere with breathing or swallowing.	_____	_____
Heart Murmurs, extra sounds, enlarged heart, pacemaker, implantable defibrillator.	_____	_____
Lungs & Chest Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezing or alveolar rales, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may lead to pulmonary tests or a chest x-ray.	_____	_____
Abdomen & Viscera Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	_____	_____
Vascular System Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	_____	_____
Genito-urinary System Hernias	_____	_____
Extremities Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp & prehension in upper limb to maintain steering wheel grip. Insufficient mobility & strength in lower limb to operate pedals properly.	_____	_____
Spine, Musculoskeletal Previous surgery, deformities, limitation of motion, tenderness.	_____	_____
Neurological Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar & Babinski's reflexes, ataxia.	_____	_____

Examiner Comments: _____

_____

_____

_____

Participant Name: _____ **Date:** _____

HEALTH HISTORY

Participant completes this section, but medical examiner is encouraged to discuss with Participant.	YES	NO
1. Any major illness or injury in the Past 5 years?		
2. Head/Brain injuries. Disorders or illnesses?		
3. Seizures, epilepsy. Medication(s): _____		
4. Eye Disorders or impaired vision (except corrective lenses)		
5. Ear disorders, loss of hearing or balance		
6. Heart disease or heart attack; other cardiovascular condition Medication(s): _____		
7. Heart surgery (valve replacement/bypass, angioplasty, pacemaker)		
8. High Blood Pressure? Medication(s): _____		
9. Muscular disease		
10. Shortness of breath		
11. Lung disease, emphysema, asthma, chronic bronchitis		
12. Kidney disease, dialysis		
13. Liver disease		
14. Digestive problems		
15. Diabetes or elevated blood sugar Controlled by: ___ Diet ___ Pills ___Insulin		
16. Nervous or psychiatric disorders, e.g., severe depression Medication(s): _____		
17. Loss of, or altered consciousness		
18. Fainting, dizziness		
19. Sleep disorders, sleep apnea, loud snoring		
20. Stroke or paralysis		
21. Missing or impaired hand, arm, foot, leg, finger, toe		
22. Spinal injury or disease		
23. Chronic low back pain		
24. Regular, frequent alcohol use		
25. Narcotic or habit-forming drug use		

For any YES answer, indicate onset date, diagnosis, treating physician's name, address, and any current limitations. List all medications (including over-the-counter medications or supplements. _____

_____

_____

_____

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination.

_____ Date _____

Participant Signature

Strive 4 life, LLC
902 East 1st Street
Merrill, WI 54452

Phone: 715-201-9600
Fax: 715-722-0155
Email: info@strive-4-life.com

Audiology Questionnaire

Name: _____ Employer: _____

Birth Date: _____ Date of Employment: _____

SSN: _____ Today's Date: _____

Please Answer:

Has it been greater than 14 hours since last exposure to loud noise?	Yes ___No ___
Have you recently experienced pain in either ear?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced a draining ear?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced dizziness (vertigo)?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced severe tinnitus (ringing)?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced sudden hearing loss?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced fluctuating hearing loss?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced ear fullness or discomfort?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently had problems wearing hearing protection?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you ever had a severe head injury?	Yes ___ No ___
Do you have frequent ear infections?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you ever been to an ear specialist?	Yes ___ No ___
Have you ever had ear surgery recommended or performed?	Yes ___ No ___
Have you ever had kidney disease?	Yes ___ No ___
Have you ever had scarlet fever?	Yes ___ No ___
Have you ever had meningitis?	Yes ___ No ___
Do you have diabetes?	Yes ___ No ___
Do you have high blood pressure?	Yes ___ No ___
Do you have existing hearing problems?	Yes ___ No ___
Do you currently use prescription or over-the-counter drugs?	Yes ___ No ___
Are you currently suffering from a cold, flu or allergies?	Yes ___ No ___
Do you shoot guns or hunt currently or ever?	Yes ___ No ___
Do you operate farm equipment or drive with window(s) down?	Yes ___ No ___
Do you participate in loud activities (music, motorcycle)?	Yes ___ No ___
Do you operate chain saws or power tools?	Yes ___ No ___
Does any of your immediate family have hearing problems?	Yes ___ No ___
Do you wear hearing aids?	Yes ___ No ___

Examiner Only:

Subject has visible wax or object in ear	Yes ___ No ___
Subject should be referred	Yes ___ No ___

_____ _____ _____ _____

Examiner Date Participant Date

Medical Examiner Comments: _____

_____

_____

_____

_____