



MEDICAL EXAMINATION

Please return to Job Discovery, Inc., at 10345 Democracy Lane, Fairfax, VA 22030

Patient Name: _____ Date Of Exam: _____

Height: _____ Weight: _____ Pulse: _____ B.P.: _____ D.O.B.: _____

Describe all medical conditions currently being treated: _____

Screening Results: (indicate if further evaluation is needed)

Test Results

Vision: _____

Blood Chemistry: _____

Hearing: _____

Urine: _____

Nutrition: _____

Tuberculosis: _____

Speech & Language: _____ Hepatitis: _____

Other (): _____ Other (): _____

Is the patient on a special diet? () YES () NO. If yes, describe the diet and the reason for it:

If the patient has seizures, describe them by indicating the type, the frequency and the length of the average seizure: _____

Recommended frequency of blood level examinations: _____

If the patient uses adaptive, corrective, mobility, orthotic or prosthetic devices, describe devices and reason needed: _____

Are all immunizations up-to-date? () YES () NO. Needed : _____

Allergies (type and reaction): _____

Physician's Signature: _____ Date: _____

