UNIVERSITY OF CENTRAL FLORIDA
EMPLOYMENT SERVICE/PHYSICAL EXAM

TO EXAMINING PHYSICIANS: This evaluation is requested to assess the applicant's ability to fulfill the minimum physical requirements of the attached job description. It is in the best interests of the applicant, the University of Central Florida, and the State of Florida that you carefully note any and all abnormalities.

Please e-mail exam results to:

Name of applicant _____ Gender: Male ☐ Female ☐
Age _____
Position applied for _____ Department _____
*Department Acct. # _____ Date and time of exam _____

***The department account number listed will be responsible for exam costs. Exam will not be conducted without account number**

SECTION A: Applicant's History - (to be completed by applicant-explain all yes answers below)

Family History: Has any member of your immediate family (father, mother, brother, sister or child) been seriously ill or died from a serious illness (e.g. Heart Disease, Cancer or Diabetes)? Yes ☐ No ☐

If **Yes**, note relation and illness:_____

Have you ever: (please mark YES or NO with "X")

	YES	NO		YES	NO
Received a pension for disability	_____	_____	Received Worker's Compensation	_____	_____
Been refused life insurance for health reasons	_____	_____	Been refused a driver's license for health reasons	_____	_____
Been refused employment for health reasons	_____	_____	Been forced to give up a job for health reasons	_____	_____
Been discharged from the military for health reasons	_____	_____	Been rejected for military service for health reasons	_____	_____
Been made ill by your work environment	_____	_____	Worked w/radio-active material	_____	_____
Had swelling of legs, ankles or feet	_____	_____	Had frequent nausea, vomiting, or diarrhea	_____	_____
Had an operation or been advised to have an operation	_____	_____	Injured your back or had back pain (chronic)	_____	_____

PATIENT NAME: _____ SS#_____

	YES	NO		YES	NO
Worked with asbestos or worked in a dusty trade	_____	_____	Had difficulty urinating or had blood in urine or stool	_____	_____
Needed glasses to read or see for distance	_____	_____	Worn contact lenses	_____	_____
Had chronic skin problems, skin rash, or Eczema	_____	_____	Had heart trouble, chest pains or Angina	_____	_____
Had a ruptured disk	_____	_____	Worn a back brace or a truss	_____	_____
Been seriously injured or ill	_____	_____	Taken medicine regularly (list below)	_____	_____
Had Varicose Veins/Phlebitis	_____	_____	Had convulsions/Epilepsy	_____	_____
Had drug reactions	_____	_____	Had allergies	_____	_____
Had hearing loss	_____	_____	Used a hearing aid	_____	_____
Worn a knee brace	_____	_____	Had Tuberculosis	_____	_____
Had Diabetes	_____	_____	Had Cancer	_____	_____
Had previous toxic exposure	_____	_____	Had high blood pressure	_____	_____
Had paralysis	_____	_____	Had joint pains or arthritis	_____	_____
Had Kidney Disease	_____	_____	Had fainting spells or dizziness	_____	_____
Had Asthma	_____	_____	Had headaches (frequent)	_____	_____
Had Rheumatic Fever	_____	_____	Had a cough (frequent or chronic)	_____	_____
Had a head injury	_____	_____	Had an abnormal electrocardiogram	_____	_____
Had Hepatitis	_____	_____	Had dental problems	_____	_____
Had stomach ulcer	_____	_____	Had shortness of breath	_____	_____
Do you smoke? (list amount below)	_____	_____	Had sexually transmitted disease	_____	_____

Explanation of **Yes** answers**:** _____

_____

I declare that all information provided by me, the applicant, is true to the best of my knowledge and hereby give permission to the examining physician to release any of the information listed on this exam form to the proper authorities at the University of Central Florida. I understand that any false information or misstatement of facts may result in my disqualification as an applicant or grounds for termination of employment.

Signature of Applicant _____ Date_____

PATIENT NAME: _____ SS#_____

SECTION B: Physical Exam (please pay special attention to problems listed below)

	Normal	Abnormal
Vital signs: HR_____BP_____Temp_____Hgt_____Wgt_____	_____	_____
Eyes: Vision Exam: R 20/_____L20/_____ Color Perception_____ EOM _____Conjuntiva_____Pupils_____	_____	_____
Ears/Hearing: Canals, Tympanic membranes, decreased auditory acuity	_____	_____
Nose & Sinuses: Deformity, obstruction, chronic infection, signs of allergy	_____	_____
Throat: Enlarged tonsils, chronic infection	_____	_____
Dentition: Caries, bite, prostheses	_____	_____
Neck Thyroid: Enlargement, Adenopathy, masses	_____	_____
Thorax: Inadequate expansion, deformity	_____	_____
Heart: Enlargement, Arrhythmia, mummers, abnormal tones	_____	_____
Blood Vessels: Bruits, decreased pulses	_____	_____
Lungs: Rales, Ronchi, wheezing, dullness, chronic infection	_____	_____
Abdomen: Organ enlargement, Inguinal Hernia, Ventral Hernia	_____	_____
Genitalia: Phimosis, hydrocele, varicocele, testicles, sores, discharge	_____	_____
Rectum & Anus: Hemorrhoids, fissure, Pilonidal Disease	_____	_____
Back: Deformity, weakness, decreased ROM	_____	_____
Extremities: Deformity, amputation, limitation of motion, chronic infection, Varicose veins, lymph nodes, edema	_____	_____
Skin: Disfiguring defects or scars, infection, lesions, rashes, tattoos	_____	_____
Neurologic: Abnormal reflexes, sensation; coordination, gait, station	_____	_____
Breasts: Nipple discharge, masses, skin changes	_____	_____
Menstruation: Abnormal in orientation	_____	_____

Does the female applicant state that she is pregnant? Yes □ No □ Date of last menstruation?_____

Physician Statement: I find this applicant to be **ACCEPTABLE / NOT ACCEPTABLE** for employment in the position for which they applied. **(Please put additional comments on a separate piece of paper and attach to this form)**

Physician's Signature: _____ Date_____

Office Address: _____Florida License #_____