

**SPRINGFIELD PUBLIC SCHOOLS  
DISTRICT NO. 186  
1900 WEST MONROE  
SPRINGFIELD, ILLINOIS 62704**

**PHYSICAL EXAMINATION**

Employee's Statement: Please answer all questions.

Name of Employee (Please print)	First	Middle	Last	Birth Date	Month	Day	Year
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**MEDICAL HISTORY:** To the best of your knowledge, do you have or have you had any disease or disorder or other as follows:

	Yes	No		Yes	No
1. Impaired health at present? . . . . .			7. (a) Lungs or bronchi? . . . . .		
			(b) Tuberculosis? . . . . .		
2. (a) Heart, blood, or blood vessels? . . . . .			(c) Pleurisy, asthma, or emphysema? . . . . .		
(b) Rheumatic fever or heart murmur? . . . . .			8. (a) Esophagus, stomach, or intestines? . . . . .		
(c) Abnormal heart rate or rhythm? . . . . .			(b) Liver or gallbladder? . . . . .		
(d) High blood pressure? . . . . .			(c) Ulcer or colitis? . . . . .		
3. (a) Diabetes or gout? . . . . .			9. (a) Genito-urinary system? . . . . .		
(b) Thyroid or glands? . . . . .			(b) Kidneys or bladder? . . . . .		
4. (a) Skin, muscles, bones, or joints? . . . . .			10. (a) Brain or nervous system? . . . . .		
(b) Arthritis? . . . . .			(b) Dizziness or unconsciousness? . . . . .		
5. Eyes or ears; uncorrected visual defect; impaired hearing? . . . . .			(c) Mental illness, epilepsy, or paralysis? . . . . .		
			(d) Encephalitis or neuritis? . . . . .		
6. Tumor or cancer? . . . . .			11. Alcoholism or drug abuse? . . . . .		
			12. Are medications currently being taken?		

LISTING BY NUMBER, DESCRIBE BELOW ALL QUESTIONS ANSWERED "YES"

Question No.	Pertinent history to include dates, severity, outcome.

TO BE COMPLETED BY PHYSICIAN:

Pulse Rate \_\_\_\_\_/min.

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Is there any arrhythmia? \_\_\_\_\_  
 If so, number \_\_\_\_\_/min.

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Blood Pressure:  
 Systolic \_\_\_\_\_  
 5th Phase Diastolic \_\_\_\_\_

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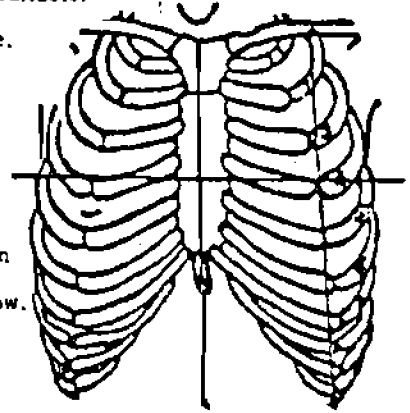
Is there any murmur? \_\_\_\_\_  
 If so, complete section at right - -

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Is there evidence of vascular  
 disease—arteriosclerosis,  
 varicosities, etc.? \_\_\_\_\_

Encircle word in each line which is most suitable.

- (a) **Time:** Systolic. Preystolic. Diastolic.
- (b) **Quality:** Harsh. Soft. Musical.
- (c) **Volume:** Grade I II III IV V VI
- (d) **Pitch:** High. Low.
- (e) **Transmitted.** Not Transmitted.
- (f) **Constant.** Inconstant.
- (g) **Hypertrophy:** None. Slight.  
Moderate. Marked.



On chart indicate quadrant of chest in  
 which murmur is most audible. If  
 transmitted, indicate direction by arrow.

What is your diagnosis?

Eyes, ears, nose or throat. \_\_\_\_\_

Lungs. \_\_\_\_\_

Abdominal organs. \_\_\_\_\_

Reflexes. \_\_\_\_\_

Endocrine system. \_\_\_\_\_

Lymphatic system. \_\_\_\_\_

Skin. \_\_\_\_\_

Genito-urinary system. \_\_\_\_\_

Do you consider applicant to be in  
 good health? \_\_\_\_\_

T.B. Test: \_\_\_\_ positive \_\_\_\_ negative

Sex	Height (in flat shoes)	Weight (clothed)
	ft. in.	lbs.

REMARKS AND DETAILS OF POSITIVE FINDINGS.

I CERTIFY THAT I HAVE EXAMINED \_\_\_\_\_.

Signature of Physician

Mailing Address of Physician

Date