



Ascent Urgent Care
& Walk-In Clinic

Pre Employment Exam

Name: _____ Date of Birth: ___/___/___ Sex: _____ Age: _____ Phone:- _____
 Name of Company: _____ PCP: _____
 Position Applied: _____
 Home Address: _____ City: _____ State: _____ Zip: _____

PLEASE MARK YES OR NO IF YOU HAD ANY OF THE FOLLOWING CONDITIONS.

Allergies	YES NO	Epilepsy	YES NO	Lung Disease	YES NO
Anemia	YES NO	Fainting	YES NO	Menstrual disorder	YES NO
Ankle swelling	YES NO	Fractured/ Broken bone	YES NO	Neuritis	YES NO
Arthritis	YES NO	Gall bladder	YES NO	Numbness	YES NO
Asthma	YES NO	Ganglion cyst	YES NO	Pinched nerves	YES NO
Back injury	YES NO	Hay fever	YES NO	Pneumonia	YES NO
Back pain	YES NO	Head Injury	YES NO	Pregnancy	YES NO
Bladder problems	YES NO	Heart trouble	YES NO	Rectal bleeding	YES NO
Bursitis	YES NO	Hernias	YES NO	Rotator cuff injury	YES NO
Cancer	YES NO	High blood pressure	YES NO	Sciatica	YES NO
Carpal Tunnel Syndrome	YES NO	Hospitalization	YES NO	Shortness of breath	YES NO
Chiropractic treatment	YES NO	Infectious diseases	YES NO	Sinus trouble	YES NO
Chronic cough	YES NO	Jaundice	YES NO	Skin condition	YES NO
Convulsions	YES NO	Kidney trouble	YES NO	Stomach trouble	YES NO
Diabetes	YES NO	Knee injury	YES NO	Surgery	YES NO
Do you smoke	YES NO	Liver disease	YES NO	Ulcers	YES NO
Eczema	YES NO	Loss of consciousness	YES NO		

Briefly explain any answer marked yes, giving dates and if that is still an ongoing problem :

Current or ongoing back problems? **YES NO** If yes, is it aggravated by lifting :(0-15 lbs) or (15-50lbs) or (greater than 50) Or Bending or Twisting? **YES NO** Prolonged standing? **YES NO**
 List all Medications: _____ Allergies: _____
 Currently under a Doctors care? **YES NO** If yes, explain _____
 Pregnant? **YES NO**
 Do you have any disabilities? _____

Please list any previous job you have held for over one year and if exposed to any potentially harmful exposures (e.g. chemicals, radiation, dusts, loud noise, or exposure to cold temperatures etc).

JOB	NUMBER OF YEARS	EXPOSURES
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I CERTIFY THAT I HAVE PROVIDED ACCURATE AND COMPLETE INFORMATION REGARDING MY HEALTH AND THAT ANY MISREPRESENTATION OR MATERIAL OMITTED MAY BE CAUSE FOR DISMISSAL. I GRANT PERMISSION TO ADVANCE URGENT CARE TO RELEASE INFORMATION PERTINENT TO THE JOB FOR WHICH I AM BEING CONSIDERED.



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Applicant signature: _____ Date: ___ / ___ / _____

Name: _____

General Appearance & Development:: Good _____ Fair: _____ poor _____

Height: _____ Weight: _____ Vision: Right Eye: _____ Left Eye: _____ Color: _____

() without corrective lenses () with corrective lenses

blood Pressure _____	lungs _____
Pulse _____	Abdomen _____
Respiration _____	Skeletal _____
Temp _____	Extremities _____
Head _____	Back _____
Mouth _____	Genito-urinary _____
Teeth _____	Skin _____
Tonsils _____	Cns _____
Neck _____	
Heart _____	
Urinalysis _____	

Urinalysis

Glucose _____ Albumin _____ Specific Gravity _____

Pease Remark:

History Of Asthma _____ if Yes What Is Treatment _____

History Of Allergies _____ if Yes What Is Treatment _____

Comments:

Ascent Urgent Care
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Provider Signature

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CARE WITH COMPASSION!