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.

Applicant signature: _____ Date: ___ / __/ _____

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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:

_____

_____

_____

_____

_____

Provider Signature

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CARE WITH COMPASSION!

