

Texas Hills Urgent Care Centers

1

Marble Falls Minor Emergency Center / Hill Country Urgent Care in Bee Cave

PRE-EMPLOYMENT PHYSICAL FORM

NAME OF PATIENT: _____ DATE OF PHYSICAL: _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S SS#: _____

POSITION APPLIED FOR: _____ DEPARTMENT: _____

HEIGHT: _____ WEIGHT: _____ BP: _____

LAST TETANUS: _____ PULSE: _____

MEDICATIONS: _____

ALLERGIES: _____

MAJOR ILLNESSES: _____

DATE LAST SEEN BY DOCTOR FOR MAJOR ILLNESS: _____

MAJOR INJURY: _____

DATE LAST SEEN BY DOCTOR FOR MAJOR INJURY: _____

GENERAL APPEARANCE: _____

EYES: _____ VISION: FAR UNCORRECTED: _____ FAR CORRECTED: _____

RIGHT 20/ _____ RIGHT 20/ _____

LEFT 20/ _____ LEFT 20/ _____

BOTH 20/ _____ BOTH 20/ _____

EARS: _____ HEARING: _____

MOUTH/THROAT: _____ SKIN: _____

CARDIOVASCULAR: _____

LUNGS: _____

ABDOMEN: _____

GENITOURINARY: _____ HERNIA: YES: _____ NO: _____

MUSCULOSKELETAL:

SPINE: _____

EXTREMITIES: _____

NEUROLOGIC: _____

REFLEXES: _____

MENTAL STATUS: _____

OTHER TESTS: _____

GENERAL IMPRESSION REMARKS: _____

PHYSICIAN'S SIGNATURE: _____

Marble Falls Minor Emergency Center: 830-798-1122; US Hwy 281

1

Hill Country Urgent Care in Bee Cave: 512-263-1600; State Hwy 71

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PRE- EMPLOYMENT PHYSICAL DEMANDS FORM (Complete by supervisor prior to physical)

DATE: _____

APPLICAN'T'S NAME: _____

POSITION APPLIED FOR: _____ DEPARTMENT: _____

1. In an 8 hour work day, position will be required to: (Circle full capacity of each activity)

a. Sit	No	1	2	3	4	5	6	7	8 (hrs)
b. Stand	No	1	2	3	4	5	6	7	8 (hrs)
c. Walk	No	1	2	3	4	5	6	7	8 (hrs)

Doctor's comments: _____

2. Position requires: (Underline one of each requirement)

a. Bend/Stoop	Not at all	Occasionally	Frequently	Continuously
b. Squat	Not at all	Occasionally	Frequently	Continuously
c. Crawl	Not at all	Occasionally	Frequently	Continuously
d. Climb	Not at all	Occasionally	Frequently	Continuously
e. Climb Height	Not at all	Occasionally	Frequently	Continuously
f. Reach above Shoulder level	Not at all	Occasionally	Frequently	Continuously
g. Crouch	Not at all	Occasionally	Frequently	Continuously
h. Kneel	Not at all	Occasionally	Frequently	Continuously
i. Balance	Not at all	Occasionally	Frequently	Continuously
j. Push/Pull	Not at all	Occasionally	Frequently	Continuously

Doctor's comments: _____

3. Position will require that he/she carry: (Underline one of each requirement)

a. Up to 10 lbs	Not at all	Occasionally	Frequently	Continuously
b. 11-24 lbs	Not at all	Occasionally	Frequently	Continuously
c. 25-34 lbs	Not at all	Occasionally	Frequently	Continuously
d. 35-50 lbs	Not at all	Occasionally	Frequently	Continuously
e. 51-74 lbs	Not at all	Occasionally	Frequently	Continuously
f. 75-100 lbs	Not at all	Occasionally	Frequently	Continuously
g. 100 lbs & over	Not at all	Occasionally	Frequently	Continuously

Doctor's comments: _____

4. Position will require that he/she lift: (Underline one of each requirement)

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a. Up to 10 lbs	Not at all	Occasionally	Frequently	Continuously
b. 11- 24 lbs	Not at all	Occasionally	Frequently	Continuously
c. 25-34 lbs	Not at all	Occasionally	Frequently	Continuously
d. 35-50 lbs	Not at all	Occasionally	Frequently	Continuously
e. 51-74 lbs	Not at all	Occasionally	Frequently	Continuously
f. 75-100 lbs	Not at all	Occasionally	Frequently	Continuously
g. 100 lbs & over	Not at all	Occasionally	Frequently	Continuously

Doctor's comment: _____

5. Position will require use of feet for repetitive movements as in operating foot controls:

Right Foot: Yes _____ No _____
Left Foot: Yes _____ No _____
Both: Yes _____ No _____

6. Position will require use of hands for repetitive action such as:

- a. Simple Grasping: Right Yes _____ No _____
Left Yes _____ No _____
- b. Firm Grasping Right Yes _____ No _____
Left Yes _____ No _____
- c. Fine Manipulation Right Yes _____ No _____
Left Yes _____ No _____

7. Position requires:

- a. Working on unprotected heights? Yes _____ No _____
- b. Being around moving machinery? Yes _____ No _____
- c. Exposure to marked changes in temperature & humidity Yes _____ No _____
- d. Driving automotive equipment Yes _____ No _____
- e. Exposure to dust, fumes & gases Yes _____ No _____

Doctor's comment: _____

Additional comments from Supervisor: _____

Signature of Applicant: _____ Date: _____

Signature of Department Supervisor: _____ Date: _____

Signature of Physician: _____ Date: _____

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