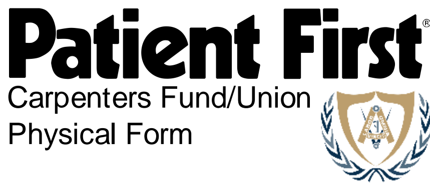

Carpenters Fund/Union
Physical Form

ICC Account #	
PA	4914
NJ	1292
MD	6439

Center#:___________ MR#:_____________

Center Stamp

For Patient Use

Last Name:	First Name:	Middle Name:	
Date of Birth (mm/dd/yyyy):	Telephone #:	Work #:	Sex:
Address:	City:	State:	Zip Code:

Please list any prescription medications you are taking currently: ______________________________

Please list any over the counter medications and/or food supplements you are taking currently: ______________________________

Please list any drug allergies that you currently have and what reaction you had: ______________________________

Are you presently under the care of a physician? No Yes If yes, please explain: ______________________________

Have you ever had or do you currently have any of the following problems?
Please check all appropriate boxes.

Alcoholism/Drug Abuse	Epilepsy/Seizures	Pancreatitis
Allergies	Fractures (Broken Bones)	Phlebitis
Anemia	Frequent Headaches	Pneumonia
Arthritis	Gall Bladder Problems	Rheumatic Fever
Asthma	Glaucoma/Cataracts	Sexual Dysfunction
Back Problems	Gout	Sexually Transmitted Disease
Bleeding Problems	Hearing Problems	Shortness of Breath
Bronchitis/Emphysema	Heart Trouble	Sickle Cell Disease/Trait
Cancer	Hemorrhoids	Skin Disorders
Chest Pain/Discomfort	Hernia	Frequent Sore Throat
Chickenpox	High Blood Pressure	Stomach/Duodenal Ulcers
Measles/Mumps/Polio	Kidney/Bladder/Prostate Problem	Stroke
Chronic Cough	Liver Problems	Tuberculosis (Tb)
Cold/Heat Intolerance	Malaria	Tension/Anxiety
Depression	Marked Weight Loss/Gain	Thyroid Problems
Diabetes	Mental Illness	Varicose Veins
Diverticulosis	Mononucleosis	Vascular Disease
Dizziness/Fainting	Osteoporosis	Other: ___________________

If yes to the above and additional details needed, please explain:

Surgery? (Please list year and reason):

Other Hospitalization? (Please list year and reason):

Serious Injuries? (Please list):

Have you been turned down for life insurance, military service, or employment because of health problems? Yes No

Do you smoke?	Yes	No	__________ packs per day for _______ years.
Do you drink alcohol?	Yes	No	__________ drinks per day.
Do you drink coffee/tea?	Yes	No	__________ cups per day.
Do you wear your seatbelt?	Yes	No	

Patient Signature: ______________________________ Date: ______________________

For Physician Use

Last Name:			First Name:	Date:
Height (inches):	Weight:	BMI:	Blood Pressure: Right:_________ Left:__________	Pulse: _______ Reg: Irreg:

Tester list the dB tested. For example, 20dB and record result as pass or fail for each frequency.*

Pass ✓ Fail ––

Distant Vision: Snellen	AUDIOMETRY SCREENING (Pass/Fail) _________dB*								
	Right Ear				______ dB* LEVEL				Left Ear
R: 20/____ Corr. To 20/_____	500Hz	1000Hz	2000Hz	4000Hz		500Hz	1000Hz	2000Hz	4000Hz
L: 20/____ Corr. To 20/_____									

**Normal hearing for adults is classified as the ability to hear between 0-25dB or as low as 25dB at the test frequencies (Hz).”*

Normal	Check each item in the appropriate column (enter NE for not evaluated)	Abnormal
	Head, Face, and Scalp	
	Neck	
	Eyes	
	Fundi	
	Ears	
	Nose	
	Mouth and Throat	
	Lungs and Chest	
	Heart	
	Vascular System (Varicosities, pulses, etc.)	
	Abdomen	
	Hernia (all types)	
	GU System (male only)	
	Upper Extremities	
	Lower Extremities	
	Spine	
	Skin/Lymphatics	
	Neurologic Exam	
	Deep Tendon Reflexes	

Comments on Abnormal Findings

CBC

WBC: ________ RBC: ________ Hgb: ________ HCT: _________

Diff/Morph: ____

EKG

HgbA1C Results

LIPID Panel

	Normal Ranges:
Fasting ______ Yes _______ No	
Cholesterol, Total _______	(100-199 mg/dL) H
Triglycerides ________	(0-149 mg/dL)
HDL Cholesterol Cal ________	(> 39 mg/dL)
VLDL Cholesterol Cal ________	(5-40 mg/dL)
LDL Chol Calc (NIH) ________	(0-199 mg/dL) H

PHYSICIAN COMMENTS:

Physician Signature: ____ **Printed Name:** ____

Routing: Fax completed physical form to Carpenter Fund Medical Management at (215) 563-0169.