PALOMAR HEALTH
Corporate Health Services

☐ Poway
Palomar Corporate Health Services – Poway
15611 Pomerado Rd, Suite 580, Poway, CA 92064
858.613.6280 858.613.6281

☑ Escondido
Palomar Corporate Health Services – Escondido
2125 Citracado Parkway, Suite 130, Escondido, CA 92029
760.510.7373 760.510.7374

Patient Registration

Patient Name _____ Date of Birth _____

Home Address: _____ SS# _____

City: _____ State: _____ Zip: _____ Phone: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W Sex: ☐ M ☐ F Spoken Language: _____

Reason for visit: _____ Date of visit: _____

Employer Data

Company Name _____ Phone: _____

Address: _____ City: _____ Zip:_____

Job Title: _____

PALOMAR HEALTH
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Employment – Medical History Questionnaire

Name (Last, First, Middle)	**Sex** ☐ Male ☐ Female	**Birthdate** (Month / Day / Year)
Employer	**Position Applying**	**Date**

I voluntarily agree to submit to an employment physical which could include blood, breath and urine screenings for communicable diseases, alcohol, drugs and general health. I understand my employment is contingent upon successful completion of the assessment.

For any questions 1–14 below that require explanation, please write in the space labeled "Explanations to 'Yes' Answers"

1. Have you ever had a work-related injury or illness? (If yes, answer question a–c below.) a. Do you have a claim(s) for a work-related injury that is pending?	☐ Yes ☐ No ☐ Yes ☐ No
b. Are you currently being treated for any work-related injury or illness? If yes, please list the injury(s) or illness(es).	☐ Yes ☐ No
c. Did you miss any time from work due to work-related injury(s) or illness(es)? If so, how many full days/weeks? Explain how long and type of disability you had.	☐ Yes ☐ No
2. Have you ever received **temporary** restrictions for an injury/illness (work-related or non work-related)? a. If yes, please write the restrictions below and provide the date they were issued.	☐ Yes ☐ No
3. Have you ever received permanent restrictions for an injury/illness (work-related or non work-related)? a. If yes, please write the restrictions below and provide the date they were issued.	☐ Yes ☐ No
4. Have you ever had any other injuries other than those noted above? a. If yes, list the previous injuries you have had and the approximate date of each.	☐ Yes ☐ No
5. Have you ever been rejected from employment as a result of a physical exam? a. If yes, explain.	☐ Yes ☐ No
6. Do you have any active medical or orthopedic problems? a. If yes, please list each problem and the date the problem started.	☐ Yes ☐ No
7. Are you taking any medications? a. If yes, please list all medications below, including over-the-counter medications you may be taking.	☐ Yes ☐ No
8. Have you seen, and do you have any medical or post-surgical condition(s) that may affect your ability to perform the job you are applying for? If yes, please list each problem and the date the problem started.	☐ Yes ☐ No
9. Have you had prior surgeries? a. If yes, please list them with the approximate date of each.	☐ Yes ☐ No
13. Have you been addicted to or consistently used drugs? If yes, explain.	☐ Yes ☐ No
14. Do you consume alcohol? If so, please specify the amount of drinks you consume each week.	☐ Yes ☐ No

Explanations to "Yes" Answers [Place the question # and your explanation(s) below]

Question #	Explanation	Physician Comment (Provider use only)

I hereby declare that, to the best of my knowledge and belief, the information given in this document is correctly recorded complete and true, and I understand that any falsification, misrepresentation or omission is cause for disqualification as an applicant or employee.

Name (print) _____ Signature _____ Date _____

Provider Review

Clinical Name (print) _____ Signature _____ Date _____

PALOMAR HEALTH
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Employment – Physical Examination & Assessment

Name (Last, First, Middle)	**Date**

Visit Vitals and Assessments

Height _____ (ft', in'') Weight _____ (lbs) Temp _____ (°F) Pulse _____ BP _____ / _____

	Uncorrected			Corrected			Comments
	Right eye	Left eye	Both	Right eye	Left Eye	Both	
Distance							
Near							

Color Testing: Ishihara: ____ / _____ plates ☐ Normal ☐ Deficient

Peripheral: R _____° **L** _____° **Depth perception:** _____ / _____

Hearing: Whisper test (5ft): Right: _____ /3 words Left: _____ /3 words ☐ Audiometry performed: (see attached)

Urine Chemstrip: Protein: _____ Glucose: _____ Specific gravity: _____ Other: _____

Physician Evaluation

As related to projected job position only	Normal (✓) Not examined (✗)	Not Normal	(If not normal, outline details below)	**Impression** (active problems only)
SKIN				
HEAD				
EYES				
EARS, NOSE, THROAT				
NECK				
CHEST & LUNGS				
HEART				
ABDOMEN				
UPPER EXTREMITIES				
BACK & SPINE				
LOWER EXTREMITIES				
NEUROLOGIC				
GENITOURINARY				
HERNIA				
OTHER				

Preliminary Clearance:

☐ No significant findings – **NO RESTRICTIONS**
☐ Medical findings correctable/not limiting – **NO RESTRICTIONS**
☐ Medical findings/History – **MODERATE RESTRICTIONS**
☐ Medical findings/History – **MAJOR RESTRICTIONS**

Clinician _____

Date _____

Pending Activities:

☐ None ☐ UDS ☐ PPD/QFT ☐ Chest X-ray ☐ Labs (Titer, UA, etc.) Other: _____

Final status: ☐ No change ☐ Action required
(after pending activities performed):

☐ Notify patient of results ☐ Letter to patient's physician, sent to patient
☐ Refer to HR ☐ Work restrictions: _____
☐ Other: _____

Clinician _____

Date _____

PALOMAR HEALTH
Corporate Health Services

Employment – Health Screening Results

Patient/ Employee to complete all items in this box ONLY

Name: _____ **Date of Exam:** _____

Company: _____ **Job Title:** _____

EXAM TYPE

☐ POST OFFER EVALUATION ☐ FITNESS FOR DUTY ☐ SURVEILLANCE

☐ DMV (Date Of Required Renewal: _____) ☐ OTHER: _____

STATUS

☐ RECOMMEND **WITHOUT** RESTRICTIONS ☐ REFER TO HR FOR ACCOMMODATIONS DISCUSSION

☐ RECOMMEND **WITH** RESTRICTIONS* ☐ MEDICAL HOLD (See below **)

☐ OTHER: _____

COMMENTS

***Medical Restrictions And Limitations (Never/No:** 0% **Occasional:** 11–33% **Frequent:** 34–67% **Repetitive:** 67–100%)

Motion Restrictions [Body parts/Restricted Activity]: _____

Push/Pull/Lift & Carry:

Employee may:	push/ pull up to	lift up to	carry up
Occasionally	_____ lbs	_____ lbs	_____ lbs
Frequently	_____ lbs	_____ lbs	_____ lbs
Repetitively	_____ lbs	_____ lbs	_____ lbs

Climbing: ☐ Should not work on scaffolding/roofs/ladders, or any unprotected raised area.

Vision Restrictions: Must wear corrective eye lenses to obtain:

☐ **Normal** distance acuity (20/20' or 20/25')

☐ **Adequate** distance acuity (20/30' or 20/40')

☐ **Normal** near vision acuity (14/14" or 14/18")

☐ **Adequate** near vision acuity (14/20" or 14/28")

Hearing Deficit: ☐ Low Frequency: (_)R (_)L

☐ Middle Frequency: (_)R (_)L

☐ High Frequency: (_)R (_)L

Verbal to: _____

Date / Time: _____

Mail / Fax / eMail Date: _____

MA/ Staff Initials: _____

Other Limitations/Recommendations: _____

_____ _____ _____

Clinician Name (print) **Signature** **Date**

PALOMAR HEALTH
Corporate Health Services

I hereby authorize:

☐ Palomar Medical Center Escondido ☐ Palomar Medical Center Poway	All requests for copies of Hospital Records are processed at: Palomar Medical Center Escondido **Attention: Medical Records Department** 2185 Citracado Parkway, Escondido, CA 92029 Phone: **760.480.7901** Fax: **760.480.7966**
☐ The Villas at Poway	15615 Pomerado Road, Poway CA 92064 Phone: **858.613.4365**
☐ Other: Name of person or facility, which has Information	

To release Protected Health Information (PHI) to:

_____ _____

Name of person or facility to receive health information | Telephone Number

Address: Street Address, City, State and Zip Code

Delivery Method:	☐ Mail	☐ PICK-UP

Information to be Released: Place your **initials** next to each category of information you authorize release of:

_____ Emergency Department Reports
_____ Discharge Summary
_____ History/Physical Exam
_____ Operative/Procedure Reports
_____ Radiology/Nuclear Medicine Reports
_____ **HIV Test Results (Human Immunodeficiency Virus)**
_____ **Psychiatric Records**
_____ Entire Records- Multiple visits ***(A PER PAGE CHARGE APPLIES $.25/page)***
_____ Electronic Documents (Available Continuing Care Documents) ***(Thumb drive fee = $7.00)***

_____ Consultation Reports
_____ Laboratory Tests
_____ Pathology Reports
_____ Drug/Alcohol Information
_____ Genetic Testing
_____ Outpatient Rehab
_____ Other/Specify_____

SPECIFY THE DATE OR TIME PERIOD FOR INFORMATION SELECTED ABOVE

Dates of Service: From _____ To: _____

Use of Information: The individual or entity identified above is permitted to use my information for the following purposes:
Please initial all that apply.

_____ Continuing Medical Care _____ Personal Copy Legal _____ Legal
_____ Insurance _____ Other (please specify) _____

Expiration Date:

☐ 3 months from date of signature below or _____ (Date)

☐ I authorize disclosure of my protected health information until the designated expiration as noted above, or revocation, whichever occurs first.

Pt Name
MR #
Date _____ Age _____
Sex: ☐ M ☐ F
Affix pt name label here

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

PALOMAR HEALTH
A California Public Healthcare District

PALOMAR HEALTH
Corporate Health Services

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to:

Palomar Health
Attention: Privacy Office
120 Craven Road, Suite 224
San Marcos CA 92078

My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless specifically required or permitted by law.

I understand I am entitled to receive a copy of this Authorization.

I hereby release my attending physicians and their associates, and the hospital and its employees and agents from any liability from the release of this information.

I agree that a photocopy or faxed copy of this authorization shall be as valid as the original.

Signature: _____ Date/Time: _____
(Patient/Legal Representative)

Patient Printed Name: _____ Patient's Date of Birth:_____

Patient's Phone #: _____ Cell Phone #: _____

If signed by other than patient, indicate relationship to patient: _____

Facility Use:

☐ DPOA-HC	☐ Conservatorship	☐ Driver's License #	☐ Other	☐ FIN:
		_____	_____	_____

Pt Name
MR #
Date _____ Age _____
Sex: ☐ M ☐ F
Affix pt name label here

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