Contra Costa Community College District

MEDICAL EXAMINATION REPORT

TO THE PHYSICIAN: The *attached* Health History should be completed by the person whose name appears below. You are requested to complete *this* entire report.

Name _____
(first, middle, last)

Address _____

_____

Class Title _____

Phone _____

WHEN COMPLETED RETURN TO:

CONTRA COSTA COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES DEPARTMENT
500 COURT STREET, 4th FLOOR
MARTINEZ, CA 94553

1. Height _____
   Weight _____

2. VISION: *Uncorrected* *Corrected*
   Right 20/____ Right 20/____
   Left 20/____ Left 20/____
   Both 20/____ Both 20/____
   ☐ Glasses ☐ Contact lenses

3. HEARING (Ordinary conversation at 20 feet considered normal.)
   Right _____/20 Hearing aid used?
   Left _____/20 ☐ Yes ☐ No

4. Head (eyes, ears, nose, mouth, throat)

5. Pulse rate _____
   Blood pressure _____/_____

6. Lungs

7. Heart (and circulatory system)

8. Nervous System

9. Abdomen, G-I tract
   Hernia?

10. Rectal:
    Fissure? Fistula? Hemorrhoids?

11. Genito-urinary

12. Urinalysis:
    Sp. gravity Albumin Sugar

13. Spine

14. Extremities

15. Skin

16. Varicose veins (severity)

17. **RECOMMENDATION AND COMMENTS:**
Candidate is physically able to perform the duties of the position for which he has applied in accordance with the job description of the position.

☐ Fit (no reservations)
☐ Fit for limited work (Please comment on any limitations of type or amount of activity suggested or recommended.)
☐ Unfit (Please comment.)

18. **SIGNATURE OF PHYSICIAN:**

→→→ _____

Date _____

19. **NAME AND ADDRESS OF PHYSICIAN** (please print)

Additional remarks regarding physical condition of the applicant may be entered on the other side of this form.

4cd–196 (Rev. 5/79)

Contra Costa Community College District

HEALTH QUESTIONNAIRE

Name _____
(first, middle, last)

Address _____

_____

Class Title _____

Phone _____

WHEN COMPLETED RETURN TO:

CONTRA COSTA COMMUNITY COLLEGE DISTRICT
HUMAN RESOURCES DEPARTMENT
500 COURT STREET, 4th FLOOR
MARTINEZ, CA 94553

TO THE APPLICANT

Medical clearance is required prior to employment by the Contra Costa Community College District. This report will be used to evaluate your medical fitness to carry out the duties of the position for which you have applied. Do not leave your present employment to accept a position in the District until you have been specifically notified to report for work.

Your cooperation in filling in this questionnaire as completely as possible will expedite the evaluation and avoid delay.

1. Birth date _____

2. Male ☐ Female ☐

3. Height _____ Weight _____

Check only the boxes that apply in the following:

4. Do you wear glasses ☐
   contact lenses ☐
   neither one ☐

5. Are you blind in one eye ☐
   both eyes ☐
   neither eye ☐

Have you ever had or do you have any of the following? Supply details on "yes" answers in space provided at end of questions. If the condition required hospitalization, check the corresponding box.

	No	Yes	Hosp.
6. Tuberculosis or other lung trouble	☐	☐	☐
7. After effects of poliomyelitis	☐	☐	☐
8. Hepatitis or jaundice	☐	☐	☐
9. Cancer	☐	☐	☐
10. Tumor	☐	☐	☐
11. Hay fever	☐	☐	☐
12. Asthma	☐	☐	☐
13. Other allergies (including sensitivity to poison oak, etc.)	☐	☐	☐
14. Diabetes or sugar in urine	☐	☐	☐
15. Pernicious anemia, leukemia or other blood disorder	☐	☐	☐
16. Mental illness or nervous breakdown	☐	☐	☐
17. Any disorder of the nervous system	☐	☐	☐
18. Epilepsy or convulsions	☐	☐	☐

	No	Yes	Hosp.
19. Severe headaches	☐	☐	☐
20. Heart trouble—including circulatory	☐	☐	☐
21. Gall bladder trouble	☐	☐	☐
22. Kidney or bladder trouble	☐	☐	☐
23. Skin trouble	☐	☐	☐
24. Any defect of bones or joints including amputations	☐	☐	☐
25. Rheumatism or arthritis	☐	☐	☐
26. Back pain or back injury	☐	☐	☐
27. Head injury	☐	☐	☐
28. Knee injury	☐	☐	☐
29. Fainting spells	☐	☐	☐
30. Shortness of breath	☐	☐	☐
31. Any complications from childhood diseases	☐	☐	☐

	No	Yes	Hosp.
32. Any eye disease or eye surgery	☐	☐	☐
33. Do you wear a hearing aid or have any problem with your hearing	☐	☐	☐
34. Any speech impairment	☐	☐	☐
35. Addiction to drugs or alcohol	☐	☐	☐
36. Rheumatic fever	☐	☐	☐
37. High blood pressure	☐	☐	☐
38. Varicose veins	☐	☐	☐
39. Stomach or duodenal ulcer or other digestive problem	☐	☐	☐
40. Rupture or hernia	☐	☐	☐
WOMEN ONLY:			
41. Any problem with menstruation period	☐	☐	☐
42. Are you pregnant	☐	☐	☐

43. Have you ever had any operation? If so, please list: (name and date of operations)

_____

44. Any other illness, injury or physical condition not named above other than childhood diseases or minor illnesses? If so, what?

_____

	No	Yes
45. Have you ever had an injury which caused you to lose time from work within the last 5 years?	☐	☐
46. Have you ever been released from employment or from the armed forces for medical or health reasons?	☐	☐
47. Have you ever received or applied for pension or compensation for disability?	☐	☐
48. Are you at present under the doctor's care for any condition?	☐	☐
49. Are you taking any medication at this time? If so, what?_____	☐	☐
50. Do you consider that there is any limitation on your ability to carry out the duties of the position?	☐	☐

Please write your own account and your own evaluation of any items to which you have answered "yes" in the above questionnaire. Include, if possible, diagnosis, date of onset, your present condition as you evaluate it and what limitations, if any, you feel it may impose on your ability to perform satisfactorily the duties of the position for which you are applying. Return this completed form to the College. The information on this questionnaire will be kept confidential.

_____

_____

_____

_____

I certify that I have provided true and complete information concerning my health. *(Any misrepresentation or material omission may be cause for dismissal.)*

Signature of Applicant: _____

Date: _____

REVIEWER:

☐ Approved

☐ Questionable

Signature _____

Title _____ Date _____