Pre-Employment Physical Exam Questionnaire

Full Name

Date of Birth

Position Applied For

Contact Information

Phone

Email

Medical History

Are you currently taking any medications?

Yes

No

If yes, please specify

Do you have any allergies?

Yes

No

If yes, please specify

Have you had any surgeries or hospitalizations?

Yes

No

If yes, please specify

Do you have any physical limitations or conditions that may affect your work?

Height

Weight

Additional Comments