REDDY & ASSOCIATES LLC
D/B/A **Reddy Medical Group**
D/B/A **Reddy Urgent Care**

132 Franklin Springs St.
Royston, GA 30662
Tel (706) 245-7371

1061 Dowdy Road STE 100
Athens, GA 30606
Tel (706) 621-7575

280 General Daniels Ave.
Danielsville, GA 30633
Tel (706) 795-2211

Reddy Urgent Care
Pre-Employment Physical Form

Athens Reddy Urgent Care Only:

Name of Administrator scheduling Exam:______________________________________

Date Scheduled: ____________________ Job Type:________________

To Be Completed by Prospective Employee PRIOR TO APPT:

____

PRINT Last Name First Name Middle Initial Date

____ ______________

Address City State Zip Code Age Date of Birth

____ ______________

Phone Number Email Sex M F

______________________________ _____________________ ________________

In Emergency Notify Relationship Phone Number

DO YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST ANY OF THE FOLLOWING CONDITIONS:
(PLEASE COMPLETE THE FOLLOWING PRIOR TO SEEING PROVIDER – DO NOT LEAVE BLANK SPACES)

	YES	NO	Don't Know
Frequent Headaches			
Eye or Ear Infections			
Sinus Trouble			
Thyroid Problems			
Frequent Colds			
Lumps or Tumors in Neck			
Asthma			
Spitting up Blood			
Chronic Cough			
Lung Trouble			
Tuberculosis			
Shortness of Breath			
Chest Pains			
Heart Murmur	YES	NO	Don't Know
Swelling of Ankles			
Low Blood Pressure			
Heartburn			
Frequent Diarrhea			
Abdominal Pains			
Liver Trouble			
Hepatitis or Jaundice			
Piles, Hemorrhoids			
Hernia or Rupture			
Kidney Stones			
Broken Bones			
Back Pain or Surgery			
Arthritis			
Deformities of Joints			
Deformities of Bones			
Missing Fingers or Toes			
Ruptured Disc in Back			
Skin Rashes			
Head Injury			
Epilepsy or Fits			
Frequent Dizziness			
Paralysis			
Loss of Memory			
Diabetes or High Sugar			
Allergies			
Allergic reaction to food			
Allergic reaction to Drugs			
Anemia			
Depression			
Anxiety or Panic Attacks			
Change in Activity Level			
High Blood Pressure			
Chronic Bronchitis			
Muscle Pain			
Sleeping Problems			
Loss of Consciousness			
Carpal Tunnel Syndrome			
Numbness of tingling of hands or feet			

Have you ever been a patient in a hospital for any reason? (Circle) YES NO

If YES, please complete the following section beginning with the most recent event:

NAME OF HOSPITAL
CONDITION TREATED FOR
DATES

1.____

2.____

3.____

4.____

5.____

6.____

Have you ever lost time from work in the past year for ANY REASON? (Circle) YES NO

If YES, Please explain: ____

____

____

____

Are you currently under the treatment or care of a physician, Nurse Practitioner or other health care provider? ______

____

____

Have you been treated in the past year? (Circle) YES NO

If YES, Please explain: ____

____

____

____

Do you SMOKE? (Circle) YES NO

If YES - What do you smoke? _______________ How many per day?___________________

How many years? __________________

Do you drink Alcohol? (Circle) YES NO

If YES - How many drinks do you drink at each sitting? _______________ How many days per week?____________

What do you drink? BEER WINE HARD LIQUOR OTHER: ____

Are you taking prescribed or over the counter medications, herbal products, vitamins or supplements? __________

____

____

Last Tetanus Shot_________________________ Hepatitis B Vaccination YES NO If YES, when? ___________________

What is your private healthcare Providers name? ____

____

Address Phone Number

I give permission to the screening healthcare provider at Athens Reddy Urgent Care to forward any abnormal findings to my healthcare provider. I understand that I am responsible for following up with my own healthcare provider on any

abnormal findings that arise during the pre-employment physical conducted by the healthcare screening provider at RUC. I understand that RUC will not provide follow-up treatment for such findings.

________________________________ ________________________ ____________
PRINT NAME SIGNATURE DATE

The information contained in this form is of a strictly confidential nature. The form will remain in the Athens Reddy Urgent Care and ____ confidential files and may be seen only by the examining healthcare provider, nurses in attendance and administrative personnel reviewing the chart for quality assurance reasons. I hereby declare the answers I have given are to the best of my knowledge.

________________________________ ________________________ ____________
PRINT NAME SIGNATURE DATE

TO BE COMPLETED BY UHC PROVIDER:

Reddy Medical Group/ Reddy Urgent Care
PRIMARY CARE SERVICE PROVIDER

VITAL SIGNS: BP_________ HR________ HEIGHT:_________ WEIGHT:____________

VISUAL ACUITY WITH WITHOUT CORRECTION:

RIGHT EYE 20/
LEFT EYE 20/
BOTH EYES 20/

LAB DATA:

URINE: SUGAR: ____________ ACETONE:_______________ ALBUMIN:__________

NAME: ____

GENERAL APPEARANCE:

NEAT POOR HYGIENE OBESE THIN AVERAGE DISTRESS NO DISTRESS

NORMAL SYSTEM ABNORMAL WITH COMMENTS:

Normal	System	Abnormal with Comments
	HEAD	
	EYES	
	EARS	
	NOSE	
	MOUTH	
	NECK	
	CHEST	
	HEART	
	LUNGS	
	ABDOMEN	
	EXTREMETIES	
	SPINE	
	NEURO	
	SKIN	
	PSYCH	

ADDITIONAL FINDINGS: ____

____

____

____

FOLLOW UP REQUIRED: ____

____

____

APPROVED FOR THE JOB DESCRIPTION: (Circle) YES NO

NOT APPROVED: (CIRCLE) YES NO

REASON: ____

____

____

APPROVED WITH RESTRICTIONS (Circle) YES NO

REASON: ____

____

____

____

______________________________	______________________________	______________
EXAMINING PROVIDER (PRINT)	EXAMINING PROVIDER SIGNATURE	DATE