

CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Alexander Freeman

VISION

Vision Without Glasses

Vision With Glasses (___ N/A)

Distant std. Type: Right ___ Left ___

Right ___ Left ___ Color Blind ___

ALLERGIES:

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

BACK AND LIMB HISTORY

Do you have or have you ever had:

YES | NO

YES | NO

- 1. Injured Knee
- 2. Injured Elbow
- 3. Injured Arm or Shoulder
- 4. Catches in the Back/Pain
- 5. Dislocation
- 6. Broken Bones
- 7. Foot or Ankle Trouble
- 8. Slipped Disc

- 9. Disc Trouble
- 10. Pain/Swelling of Joints
- 11. Hand or Wrist Pain
- 12. Neck Pain
- 13. Muscle Sprain or Strain
- 14. Back Strain or Sprain
- 15. Physical Restrictions Regarding
Any of The Above
- 16. Other

Please explain ALL "YES" answers:

(Please include dates of injury.)

I have reviewed the answers to the "Back and Limb History" above and state that these answers have been recorded accurately and are true and complete responses to these questions.

Date: _____ Applicant Signature: _____

Check whether:

Normal (N), Abnormal (A), Not Performed (O)

- | | | | |
|--------------------------|-------|-------|-------|
| 1. Eyes | ___ N | ___ A | ___ O |
| 2. Visual Field | ___ N | ___ A | ___ O |
| 3. Hernias | ___ N | ___ A | ___ O |
| 4. Spine | ___ N | ___ A | ___ O |
| 5. Extremities | ___ N | ___ A | ___ O |
| 6. Hand Function | ___ N | ___ A | ___ O |
| 7. Neurological, General | ___ N | ___ A | ___ O |
| 8. Lung Capacity | ___ N | ___ A | ___ O |

COMMENTS:(Exam notes/results)

Patient here for repeat PFT's. Good

Passed repeat PFT'S

H. Thoreson PA-C

