

CMG HEALTH PROVIDER FORM

Revised 9/06

PATIENT'S NAME: Angela Marquez

VISION

Vision Without Glasses

Distant std. Type: Right 20/20 Left 20/20

Vision With Glasses N/A

Right _____ Left _____

Color Blind Pass

ALLERGIES:

ABILITY TO WORK 6-10' ABOVE GROUND LEVEL

BACK AND LIMB HISTORY

Do you have or have you ever had:

	YES	NO
1. Injured Knee	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Injured Elbow	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Injured Arm or Shoulder	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Catches in the Back/Pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Dislocation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Broken Bones	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Foot or Ankle Trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Slipped Disc	<input checked="" type="checkbox"/>	<input type="checkbox"/>

	YES	NO
9. Disc Trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10. Pain/Swelling of Joints	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. Hand or Wrist Pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. Neck Pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Muscle Sprain or Strain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
14. Back Strain or Sprain	<input checked="" type="checkbox"/>	<input type="checkbox"/>
15. Physical Restrictions Regarding Any of The Above	<input type="checkbox"/>	<input type="checkbox"/>
16. Other	<input type="checkbox"/>	<input type="checkbox"/>

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: 1/11/08

Applicant Signature: Angela Cardona Marquez

Check whether:

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

1. Eyes	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
2. Visual Field	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
3. Hernias	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
4. Spine	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
5. Extremities	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
6. Hand Function	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
7. Neurological, General	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O
8. Lung Capacity	<input checked="" type="checkbox"/> N	<input type="checkbox"/> A	<input type="checkbox"/> O

COMMENTS:(Exam notes/results)

PFT's > OK > Passed

Exam - Difficult due to language barrier. However, complete exam performed, and within normal limits.

H. Tharson PA-C

