

Youngstown Ohio OP LLC DBA
Workmed
6426 Market Street
YOUNGSTOWN, OH 44512
330-884-2025

Results Sheet
For Location: Youngstown OH OP Serv LLC

To: **CORPORATE MANAGEMENT GROUP**
LINCOLN MOONEY
12000 N WASHINGTON ST STE 350
Denver, CO 80241

Ph #: **330-920-1425**

RE: **JAMES GIGAX** **381-78-8513**

Occupation: _____

Date of Service: 03/31/2016

Type of Service: PPE Pre-Placement Exam

Procedure ID: PRE POST EMPLOYMENT PHYSICAL

Results of Physical Exam (Circle One)

Qualified

Not Qualified

Name of Examining Doctor: Physical Exams

WorkMed Representative:  _____



Name: JAMES GUGOX

Company: _____

Position: SKW operator

Home address/street 106 Wilhelm St

Home phone: (330) 937 8791

City: STRUTHERS State: Oh Zip: 44471

Work phone: (____) _____

Social Security Number: 381-78-8513

Date of Birth: 9/26/63

Medical History

Mark with a ✓ if you have ever been diagnosed as having any of the following. Explain all "Yes" answers below:
If none of the below are applicable, please mark o None

<p>Yes</p> <p><input checked="" type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Angina</p> <p><input checked="" type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Back injury</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Dermatitis</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Drug</p> <p><input type="checkbox"/> Alcohol abuse</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Eyes/ears/nose disorder</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy/Seizures</p> <p><input type="checkbox"/> Exposure to loud or continuous noise</p>	<p>Yes</p> <p><input checked="" type="checkbox"/></p> <p><input type="checkbox"/> Fainting/dizziness</p> <p><input type="checkbox"/> Fractures/dislocations</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Gastrointestinal disorder</p> <p><input type="checkbox"/> Genitourinary disorder</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Hay Fever</p> <p><input type="checkbox"/> Hearing problem</p> <p><input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Hodgkin's disease</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Joint problems</p>	<p>Yes</p> <p><input checked="" type="checkbox"/></p> <p><input checked="" type="checkbox"/> Kidney problems</p> <p><input checked="" type="checkbox"/> Knee problems <u>arthritis</u></p> <p><input checked="" type="checkbox"/> Leukemia</p> <p><input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> Loss of memory</p> <p><input type="checkbox"/> Lung disease</p> <p><input type="checkbox"/> Menstrual difficulties</p> <p><input type="checkbox"/> Nervous problem</p> <p><input type="checkbox"/> Psychiatric disorders</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Sleep Disorders</p> <p><input type="checkbox"/> Sleeplessness</p> <p><input type="checkbox"/> Thyroid</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal disease</p> <p><input type="checkbox"/> Weight loss/gain</p> <p><input type="checkbox"/> Zoster (shingles)</p>
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If Yes Explain: "old KNEES" arthritis

Allergies to Medications: TETANUS

Current Medications: NORCO - knees

Surgical History: Tonsils / Appedix

Smoking History: Do you smoke Yes No Quit 1pK Amount per day

Immunization/Infection Hx:	
<u>Infection</u> or <u>IMMUNIZATION / DATE</u>	<u>Infection</u> or <u>IMMUNIZATION / DATE</u>
Chicken Pox <u>childhood</u>	Hepatitis _____
Measles <u>childhood</u>	Tetanus _____
Mumps <u>childhood</u>	Other _____
Rubella _____	

EMPLOYEE: I hereby certify the above information is correct and truthful to the best of my knowledge. I am aware that medical information obtained during this examination will be made available to my employer or prospective employer and hereby give my consent to release this medical information to said parties. I also request and consent to the necessary physical examination as requested by my employer or other parties.

Signature: James Gugox Date 3/31/10

Name: James Higy Social Security Number: _____ Date of Birth: 9-26-63

Physical Examination

Height: 69" Weight: 211 Blood Pressure: 115/71 Pulse: 64

Near Vision (Circle one) Far Vision (Circle one)
Uncorrected / Corrected Uncorrected / Corrected Horizontal fields: Depth Perception
Right 20/ 50 Left 20/ 35 Right 20/ 30 Left 20/ 30 Right 85 Left 85 Pass _____ Fail X
b 20/35 b 20/30 130

Color Vision: Pass X Fail _____ Ishihara Pass _____ Fail _____

Hearing: Whisper N A Audiometry:
Right _____ _____ Right 500 10 1000 15 2000 10 3000 15 4000 55 6000 20 8000 25
Left _____ _____ Left 500 10 1000 15 2000 30 3000 55 4000 65 6000 50 8000 30

N	A	CATEGORY
<input checked="" type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Head
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Eyes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ears
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Nose, mouth throat
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neck
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lymph nodes
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Thorax/Lungs
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Heart
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurological exam
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Skin
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Back exam
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Extremities
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Surgical scars/tattoos <u>neck tattoo</u>
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Hernia (males only)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Genitalia (males only)

Exam Normal Comments: _____

- A. Cleared for duty
- B. Clearance pending review of further information
- C. Not cleared

Comments: _____

[Signature]

Date: 3/31/16

PHYSICIAN'S SIGNATURE

- Address: **WorkMED** 6426 Market Street Boardman, OH 44512 (330) 884-2020 Voice (330) 726-9136 Fax
- WorkMED** 20 Ohltown Road Youngstown, OH 44515 (330) 884-1500 Voice (330) 884-1501 Fax
- WorkMED** 8747 Squires Lane Warren, OH 44484 (330) 841-5444 Voice (330) 841-5441 Fax