



UNLIMITED, Inc.
Your Safety is Our Business®



888-309-SAFE (7233)



866-869- 7097



info@safetyunlimited.com

HEALTH APPRAISAL (This side to be completed by applicant)

Date: _____

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Sex: _____

Medical History

Abdominal Pain Yes No

Allergies Yes No

If yes, list: _____

Anemia Yes No

Anxiety Yes No

Asthma Yes No

Back Pain/Injury Yes No

Depression Yes No

Diabetes Yes No

Eating Disorder Yes No

Epilepsy/Seizure Yes No

Headaches/Migraines Yes No

Head Injury/Concussion Yes No

Hearing Problems Yes No

Heart Disease/Murmur Yes No

Other (please describe): _____

Hernia Yes No

Kidney Disease Yes No

High Blood Pressure Yes No

Liver Disease/Hepatitis Yes No

Surgery Yes No

Date & Type: _____

Thyroid Disease Yes No

Ulcers Yes No

Vision Problems Yes No

Smoke Yes No

Packs per week: _____

Alcohol Use Yes No

Drinks per week: _____ Drinks per month: _____

Drug Use Yes No

Type/Frequency: _____

Current medications / herbs / supplements: Yes No List: _____

Are you currently under a physician's care? Yes No

If yes, physician's name & reason for care: _____

Have you been hospitalized in the past two (2) years? Yes No

If yes, give reason for hospitalization: _____

Have you ever failed a physical examination? Yes No

If yes, please explain reason(s): _____

Date of last menstrual period: _____

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Corporate Office & Simi Valley Training Center
2139 Tapo St Suite 228
Simi Valley, CA 93063

Simi Valley EMS Training Center
2139 Tapo St Ste 111
Simi Valley, CA 93063

Simi Valley Winifred Training Center
2132 Winifred St
Simi Valley, CA 93063

Glendale, AZ Training Center
5730 W. Peoria Ave Ste 102
Glendale, AZ 85302



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This information may be shared with the department requesting the Health Appraisal and/or the medical facility to which I may be assigned.

The above information is true and correct to the best of my knowledge.

Signature

Date

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PHYSICAL EXAMINATION

(This side to be completed by Physician/Examiner)

Name: _____

Height: _____ Weight: _____ B/P: _____ Pulse: _____

Vision Screening: Right: 20/ _____ Left: 20/ _____ Both: 20/ _____

With glasses: Right: 20/ _____ Left: 20/ _____ Both: 20/ _____

Hearing Screening: Right: _____ Left: _____

EXAMINATION

Basic Exam

		Yes	No	Comments
General:	Alert, well appearing, no apparent distress.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears:	Canal without tenderness or exudate.	<input type="checkbox"/>	<input type="checkbox"/>	_____
	TMs good landmarks/light reflex, no erythema.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus:	Patent nares; no sinus tenderness to palpation.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharynx:	No erythema, exudate; tonsillar enlargement.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck:	Supple, no adenopathy; no thyromegaly.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs:	Equal breath sounds; no respiratory distress; no wheezes, ronchi or rales.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart:	Regular rhythm; no murmurs, gallops or rubs.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen:	Active BS; soft; no tenderness, guarding, masses or organomegaly; no CVA pain.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin:	No rashes, petechiae or other lesions.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuro:	DTRs +2 bilaterally; strength 5+/5+; Romberg negative.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back:	Straight, full ROM	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:				_____



Accepted for Program: Yes No

Physician/FNP Signature

Date

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