OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM

PHYSICAL EXAMINATION FORM

(See Form ARS-182A/B for Privacy Act Notification)

EMPLOYER

United States Department of Agriculture

EMPLOYEE'S LAST NAME	FIRST NAME	SOCIAL SECURITY NO.

HEIGHT	WEIGHT	PULSE	BLOOD PRESSURE
_____ Feet _____ Inches	_____ Pounds	_____ Beats/Min.	_____ _____

INSTRUCTIONS: Place an "X" in the appropriate box. Comment on all abnormal findings.

General	*Normal* ☐	*Abnormal* ☐	
Skin	*Normal* ☐	*Abnormal* ☐	
Lymph Nodes	*Normal* ☐	*Abnormal* ☐	
HEENT	*Normal* ☐	*Abnormal* ☐	
Neck	*Normal* ☐	*Abnormal* ☐	
Breasts	*Normal* ☐	*Abnormal* ☐	
Lungs	*Normal* ☐	*Abnormal* ☐	
Heart	*Normal* ☐	*Abnormal* ☐	
Abdomen	*Normal* ☐	*Abnormal* ☐	
Back	*Normal* ☐	*Abnormal* ☐	
Extremities	*Normal* ☐	*Abnormal* ☐	
Genital	*Normal* ☐	*Abnormal* ☐	
Rectal	*Normal* ☐	*Abnormal* ☐	
Neurological	*Normal* ☐	*Abnormal* ☐	

IMPRESSIONS	Do Not Write In This Section *(For Contractor Use Only)*
1.	
2.	
3.	
4.	
5.	

SIGNATURE OF EXAMINING PHYSICIAN | **Date** *(Month, Day, Year)*