111 Juliad Court
Suite 103
Fredericksburg, VA 22406
www.pdra660.com

MEDICAL PHYSICAL FORM

Name_______________________________________Date of Birth ____________________

Address____

City:_____________________________ State:_____________ Zip: __________________

Signature:___________________________________ Date: ________________________

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING: (For each "yes" checked describe conditions in remarks)

Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION
		a. frequent or severe headaches			g. heart trouble			m. nervous trouble of any sort			s. medical rejection from service
		b. dizziness or fainting spells			h. high or low blood pressure			n. any drug or narcotic habit			t. admission to hospital
		c. unconsciousness for any reason			i. stomach trouble			o. excessive drinking habit			u. rejection for life insurance
		d. eye trouble except glasses			j. kidney stone or blood in urine			p. attempted suicide			v. record of traffic convictions
		e. hay fever			k. sugar or albumin in urine			q. motion sickness requiring drugs			w. record of other convictions
		f. asthma			l. epilepsy or fits			r. military medical discharge			x. other illnesses

REMARKS: (if no changes since last report, so state) ______________________________

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MEDICAL TREATMENT WITHIN THE PAST FIVE YEARS

Date	Name of Physician Consulted	Reason

______________________________________ ______________________

SIGNATURE OF APPLICANT DATE

APPLICANTS' DECLARATION: ***I hereby certify that all statements and answers provided by me in this examination form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for insurance of any PDRA certificate to me.***

REPORT OF MEDICAL EXAMINATION

NORMAL	ABNORMAL	CHECK EACH ITEM IN APPROPRIATE BOX
		1. Head, face, neck and scalp
		2. Nose
		3. Sinuses
		4. Mouth and throat
		5. Ears, general (internal and external canals)
		6. Ear Drums (perforation)
		7. Eyes, general (visual activity under items 50 & 51)
		8. Ophthalmoscopic
		9. Pupils (equality and reaction)
		10. Ocular mobility (associated parallel movement, mystaginus)
		11. Lungs and chest (including breasts)
		12. Heart (thrust, size, rhythm sounds)
		13. Vascular system
		14. Abdomen and viscera (including hernia)
		15. Anus and rectum (hemorrhoids, fistula, prostate)
		16. Endocrine system
		17. G-U system
		18. Upper and lower extremities (strength, range of motion)
		19. Spine other musculoskeletal
		20. Identifying body marks, scar, tattoos
		21. Skin and lumphatic
		22. Neuralgic (tendon, reflexes, equilibrum, senses, coordination)
		23. Psychiatric (specify any personality deviation)
		24. General Systemic

NOTES: Describe every abnormality in detail, enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

Corrective lens required while driving		FIELD OF VISION	DISTANT VISION		NEAR VISION
[ ]NO* if previously "yes", please include explanation of change	[ ] YES	[ ] Normal	Right eye	20/	20/
		[ ] Abnormal	Left eye	20/	20/
			Both eyes	20/	20/

FIELD OF VISION		BLOOD SUGAR TEST (both fasting and 2 hour post prandial, required only if sugar is found in urine No SL Units)			
RIGHT EYE	LEFT EYE	FASTING	2-HOUR P.P.	HgA IC	COMMENTS

BLOOD PRESSURE			PULSE (WRIST)		
Recumbent MM Mercury	Systolic	Diastolic	Resting	After Exercise	2 minutes after exercise

URINALYSIS		ECG (Date) Req 55 or over	OTHER TESTS
Albumen	Sugar		

DISQUALIFYING DEFECTS/LIMITATIONS:

COMMENTS ON HISTORY AND FINDINGS:

APPLICANTS NAME:	FURTHER EVALUATION REQUIRED (EXPLAIN):
PHYSICALLY ACCEPTABLE	

MEDICAL EXAMINER'S DECLARATION: I hereby certify that I personally examined the applicant on this medical examination report, and this report and any attachment embodies my finding completely and correctly.

EXAMINATION DATE	MEDICAL EXAMINER'S NAME AND ADDRESS	MEDICAL EXAMINER'S SIGNATURE