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)*