



Physical Examination Form

ALL OPERATOR PROGRAMS

Please type or print neatly.

NAME: FIRST _____		MIDDLE _____		LAST _____	
SOCIAL SECURITY # _____		DATE OF EXAMINATION _____			
MAILING ADDRESS _____				PHONE _____	
CITY _____				STATE _____	ZIP _____

HEALTH HISTORY

Yes	No	Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease, or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN

GENERAL APPEARANCE AND DEVELOPMENT:

<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<input type="checkbox"/> Without corrective lenses	<input type="checkbox"/> With corrective lenses	

VISION: For distance ☐ Right/20 ☐ Left/20 ☐ Both/20

Evidence of disease or injury: Right _____ Left _____

Color test: Right _____ Left _____

Horizontal field of vision: Right _____ Left _____

HEARING: Right ear _____ Left ear _____

Evidence of disease or injury: Right ear _____ Left ear _____

AUDIOMETRIC TEST: ☐ 500 HZ ☐ 1000 HZ ☐ 2000 HZ ☐ 3000 HZ ☐ 4000 HZ

☐ 5000 HZ ☐ 6000 HZ ☐ 7000 HZ ☐ 8000 HZ

THROAT: _____

THORAX: Heart: _____

If organic disease is present, is it fully compensated? _____

Blood pressure: Systolic _____ Diastolic _____

Pulse: Before exercise _____ Immediately after _____

Lungs: _____

ABDOMEN: Scars _____ Abdominal masses _____ Tenderness _____

Sample Physical Exam Form

**United States. Selective Service
System (1940-1947)**



Sample Physical Exam Form:

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Table of Contents Sample Physical Exam Form

1. Understanding the eBook Sample Physical Exam Form
 - The Rise of Digital Reading Sample Physical Exam Form
 - Advantages of eBooks Over Traditional Books
2. Identifying Sample Physical Exam Form
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Sample Physical Exam Form
 - User-Friendly Interface
4. Exploring eBook Recommendations from Sample Physical Exam Form
 - Personalized Recommendations
 - Sample Physical Exam Form User Reviews and Ratings
 - Sample Physical Exam Form and Bestseller Lists
5. Accessing Sample Physical Exam Form Free and Paid eBooks
 - Sample Physical Exam Form Public Domain eBooks
 - Sample Physical Exam Form eBook Subscription Services
 - Sample Physical Exam Form Budget-Friendly Options
6. Navigating Sample Physical Exam Form eBook Formats
 - ePub, PDF, MOBI, and More
 - Sample Physical Exam Form Compatibility with Devices
 - Sample Physical Exam Form Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Sample Physical Exam Form
 - Highlighting and Note-Taking Sample Physical Exam Form
 - Interactive Elements Sample Physical Exam Form
8. Staying Engaged with Sample Physical Exam Form

- Joining Online Reading Communities
- Participating in Virtual Book Clubs
- Following Authors and Publishers Sample Physical Exam Form
- 9. Balancing eBooks and Physical Books Sample Physical Exam Form
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Sample Physical Exam Form
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Physical Exam Form
 - Setting Reading Goals Sample Physical Exam Form
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sample Physical Exam Form
 - Fact-Checking eBook Content of Sample Physical Exam Form
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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