ExpressHEALTH Clinic

DOT Physical Examination Registration

Today's Date	Are you a New Patient: ☐ YES ☐ NO	**Do you require a DOT drug screen today? ☐ YES ☐NO**

PATIENT INFORMATION

Patient Full Legal Name (First) (Middle) (Last)	Date of Birth	Sex ☐ Male ☐ Female
Address (Number) (Street) (Apt. No.)	City	State / Zip
Driver's License # / Social Security #	Phone (Home)	Phone (Cell)
Emergency Contact Name ('ER Contact') / Relationship:	Contact Phone	Circle information that may be shared with ER Contact: All Medical Financial None

List **ALL** medications you are currently taking:

Smoking Status: ☐ NO ☐ YES ☐ Previously Packs per Day: # Years:

---IF THE EMPLOYER IS THE FINANCIALLY RESPONSIBLE PARTY, complete the following Information---

The Following Party is responsible for the cost of services to the Patient:	Employer
Address / City / State / Zip	
Phone #	Contact

MEDICAL HISTORY: It is a violation of law to intentionally provide false or incomplete medical history, punishable by fine

Please answer ALL of the following questions "yes/no"

	YES	NO		YES	NO
Do you have any history of heart disease?			Do you use oxygen?		
Do you have a heart murmur or irregular heart rhythm?			Do you have COPD (chronic bronchitis) or Asthma?		
Have you ever had a heart attack?			Do you have Sleep Apnea or use a CPAP?		
Do you have any heart valve problems?			Do you have Diabetes?		
Do you have a pacemaker or defibrillator?			Do you use insulin or Byetta?		
Do you take blood thinners?			Do you have Diabetic Retinopathy?		
Have you ever had a stroke, mini stroke, or aneurysm?			Do you have peripheral neuropathy?		
Have you ever had a spine or brain injury?			Do you have kidney disease?		
Have you ever had spinal meningitis, encephalitis, or other infection of the brain or spinal cord?			Have you ever had a seizure or been told you have Epilepsy?		
Have you ever had an injury or surgery to your back or neck?			Do you have any deformity of a hand, arm, leg, or foot?		
Do you have a history of a neurological disorder (e.g. Parkinson's, Multiple Sclerosis)?			Do you wear glasses/contacts or have vision in only one eye?		
Do you have any mental/emotional disorder (depression, anxiety, Bipolar Disorder)?			Do you use a hearing aid?		
Do you take any medication that requires labs for plasma concentrations (e.g. Depakote, Lithium)?			Do you use alcohol? If Yes, circle ONE: Socially Frequently Daily		

Reviewed By: , FNP