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Medical Examination

Please return to Job Discovery, Inc., at 10345 Democracy Lane, Fairfax, VA 22030

Patient Name: _____ **Date Of Exam:** _____

Height: _____ **Weight:** _____ **Pulse:** _____ **B.P.:** _____ **D.O.B.:** _____

Describe all medical conditions currently being treated:

_____

_____

Screening Results: (indicate if further evaluation is needed) ☐ YES ☐ NO.

Test Results

Vision: _____ **Blood Chemistry:** _____ **Hearing:** _____

Urine: _____ **Nutrition:** _____ **Tuberculosis:** _____

Speech & Language: _____ **Hepatitis:** _____

Other ( ): _____ **Other** ( ): _____

Title

Is the patient on a special diet? ☐ YES ☐ NO. If yes, describe the diet and the reason for it:

_____

_____

If the patient has seizures, describe them by indicating the type, the frequency and the length of the average seizure:

_____

_____

Recommended frequency of blood level examinations: _____

If the patient uses adaptive, corrective, mobility, orthotic or prosthetic devices, describe devices and reason needed:

_____

_____

Are all immunizations up-to-date? ☐ YES ☐ NO. Needed : _____

Allergies (type and reaction): _____

Physician's Signature: _____ Date: _____

Funding Provided by: Alexandria, Arlington, Fairfax/Falls Church & Prince Williams CSB's, Commonwealth of Virginia, & Host Employers