Sentry Anesthesia Management, LLC
Southern Crescent Anesthesiology, PC
Southern Crescent Nurse Anesthesia, LLC

EMPLOYEE PHYSICAL

Name _____ DOB _____ Age _____

Home Address _____

Home Phone _____ Email _____

MEDICAL HISTORY

1. Significant Medical History? YES NO (if YES, please describe in detail)
   _____
   _____
2. Allergies to any medication? YES NO Any other allergies? YES NO If YES, please list:
   _____
3. Please list any medications you are presently taking or circle none: NONE
   _____
   _____

EXAMINATION

Male_____ Female_____ Height_____ Weight_____

Blood Pressure Reading _____ Pulse_____

Physician Observation: Heart_____ Lungs_____

General Physical Condition (please circle): Excellent Good Fair Poor

PPD

X-ray Recommended _____ X-ray Report _____

Or

TB Skin Test: _____ _____ Result: _____
Date Administered Date Read

Physician Statement

I certify that I have reviewed the medical history and examined the above name patient and I DO DO NOT find the person physically able to perform this job.
Circle one

Additional Comments:_____

_____ _____ _____
Physician Signature Printed Name Date