

UNITED STATES RUBBER COMPANY MEDICAL DEPARTMENT

PREPLACEMENT/REEMPLOYMENT HEALTH EVALUATION

LOCATION

NAME	LAST	FIRST	MIDDLE	SEX	DATE OF BIRTH	AGE
				☒ M ☐ F	FEB. 18, 1933	32
HOME ADDRESS	STREET	CITY	STATE	PHONE		
NOTIFY IN EMERGENCY					PHONE	
FAMILY PHYSICIAN					PHONE	EV
JOB APPLIED FOR:	PRODUCTION			MARITAL STATUS	DATE OF EXAM.	
				S ☒ M ☐ W ☐ D ☐ SEP	OCT 22 1965	

(TO BE FILLED IN BY APPLICANT)

The applicant is requested to complete the first two pages of this form. Please use care and accuracy in answering the following questions.

Have you ever had any of the following illnesses? Check (✓) Yes or No. If Yes indicate age when condition occurred.

	YES	NO	AGE
Scarlet Fever	☐	☒	
Diphtheria	☐	☒	
Rheumatic Fever	☐	☒	
Pneumonia	☐	☒	
Typhoid Fever	☐	☒	
Infantile Paralysis	☐	☒	
Pleurisy	☐	☒	
Heart Trouble	☐	☒	
Asthma	☐	☒	
Hay Fever or Hives	☐	☒	
Epilepsy or Fits	☐	☒	
Malaria	☐	☒	
Venereal Disease	☐	☒	
Syphilis	☐	☒	
Arthritis or Rheumatism	☐	☒	
Allergy	☐	☒	

Have you ever had any of the following symptoms? Check (✓) Yes or No. If Yes indicate age when symptom occurred.

	YES	NO	AGE
Eye Trouble or Injury	☒	☐	27
Defective Vision	☐	☒	
Sinus Trouble	☐	☒	
Frequent Colds	☐	☒	
Running Ears	☐	☒	
Defective Hearing	☐	☒	
Frequent Nose Bleeds	☐	☒	
Chronic Cough	☐	☒	
Blood Spitting	☐	☒	
Chest Pain or Pressure	☐	☒	
Shortness of Breath	☐	☒	
High Blood Pressure	☐	☒	
Rapid Pulse	☐	☒	
Palpitations	☐	☒	
Swelling of Ankles	☐	☒	
Stomach Trouble	☐	☒	

	YES	NO	AGE
Vomiting of Blood	☐	☒	
Indigestion or Heartburn	☐	☒	
Bloody or Black Stools	☐	☒	32
Yellow Jaundice	☐	☒	
Kidney or Bladder Trouble	☐	☒	
Blood in Urine	☐	☒	
Neuritis or Neuralgia	☐	☒	
Back Trouble or Lumbago	☐	☒	36
"Trick" or Locked Knee	☐	☒	
Frequent or Severe Headaches	☐	☒	
Nervous Breakdown	☐	☒	
Difficulty in Sleeping	☐	☒	
Fainting or Blackout Spells	☐	☒	
Numbness and Tingling	☐	☒	
Loss of Memory	☐	☒	
Difficulty in Concentrating	☐	☒	

FAMILY HISTORY

Please give age and state of health of your mother, father, sisters, brothers, wife and children. If deceased indicate age at death, and cause if known.

WIFE 33 GOOD
 DAUGHTER 7 GOOD
 " " 13 GOOD
 MOTHER 56 GOOD
 FATHER 53 GOOD
 SISTER 31 GOOD
 SISTER 25 GOOD

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Has anyone in your immediate family (mother, father, sister, brothers, wife, children) ever had any of the following conditions? Check (✓) Yes or No. If Yes please indicate relative and briefly describe the illness (age at onset, duration, etc.)

YES	NO	
☐	☒	Tuberculosis
☐	☒	High Blood Pressure
☐	☒	Heart Trouble
☐	☒	Epilepsy or Fits
☐	☒	Diabetes
☐	☒	Hay Fever or Hives
☐	☒	Migraine Headaches
☐	☒	Loss of Hearing
☐	☒	Mental Disorder
☐	☒	Tumor or Cancer

WIFE IN FALL MODERATE STUFFED NOSE SNEEZING

MILITARY SERVICE RECORD

- 1 - Have you ever served in the Armed Forces of the United States? Yes ☒ No ☐
- 2 - Which branch? (Army) Navy, Marines etc.)
- 3 - Give dates of service. MAR 26, 1953 - MAR 19, 1955
- 4 - Were you ever rejected or discharged by the military service for medical reasons?
Yes ☐ No ☒ If Yes, state reason.

PREVIOUS OCCUPATIONS

(List most recent job first, then next most recent, etc.)

	EMPLOYED BY	FROM	TO	NATURE OF WORK
1	<u>OSTER MFG CO</u>	<u>AUG 1963</u>	<u>DEC 1965</u>	<u>BENCH ASSEMBLY LIGHT MACHINE RE</u>
2	<u>CHESTERLAND GULF</u>	<u>MAY 1958</u>	<u>AUG 1963</u>	<u>DRIVE TRUCK PUMPS REPAIR CARS</u>
3	<u>OHIO BELL TELEPHONE</u>	<u>JUNE 1951</u>	<u>MAY 1958</u>	<u>MECHANIC REPAIR CARS + SMALL TRUCKS</u>
4				
5				

Check (✓) Yes or No for the following questions. If Yes please give brief explanation, with dates if possible.

- | | | |
|-------------------------------------|-------------------------------------|--|
| YES | NO | |
| ☐ | ☒ | 1 - Have you ever been hospitalized for any reason? _____ |
| ☐ | ☒ | 2 - Have you ever been a patient in a sanitarium or rest home? _____ |
| ☐ | ☒ | 3 - Have you ever been refused or rated up for Life Insurance? _____ |
| ☒ | ☐ | 4 - Have you lost time from work due to illness in the past 3 years? <u>YES HAD THE FLU AT TWO DIFFERENT TIMES LOST ABOUT 6 DAYS WORK</u> |
| ☒ | ☐ | 5 - Have you ever received disability payments for any injury or disease? <u>HAD LEGS SQUEEZED BETWEEN TWO CARS WHILE WORKING IN SERVICE STATION</u> |
| ☐ | ☒ | 6 - Are you sensitive (allergic) to any drugs or medications? <u>NOT THAT I KNOW OF HAVEN'T HAD TO HAVE THAT MUCH MEDICATION</u> |
| ☐ | ☒ | 7 - Have you ever had a persistent or recurrent skin disorder? _____ |
| ☒ | ☐ | 8 - Have you ever had any fractured or broken bones? <u>BROKEN RIGHT ARM WHEN ABOUT 8 YEARS OLD</u> |
| ☐ | ☒ | 9 - Have you ever been advised to have a surgical operation? _____ |
| ☐ | ☒ | 10 - Have you gained or lost more than 10 pounds in the past 3 years? _____ |

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I hereby declare that the above answers are true and understand that falsification may be grounds for discharge.

Ruth S. Rabin RN.
WITNESS

SIGNED _____
DATE 10/28/65

(NOT TO BE FILLED IN BY APPLICANT)

Physician's elaboration and comments on all significant data listed by applicant, (on female applicants include brief history of catamenia).

No swelling back Lx. No significant findings.

PHYSICAL EXAMINATION

GENERAL APPEARANCE	<i>Muscular, healthy.</i>					TEMP.	HEIGHT	WEIGHT
SKIN	ERUPTIONS, LESIONS, SCARS, ETC. <i>Clear - Scar, upper lip</i>						<i>56 1/2</i>	<i>134 1/2</i>
EYES	CORNEAE, CONJUNCTIVAE, PUPILS, FUNDI, ETC. <i>n n n</i>							
	VISUAL ACUITY	DISTANT	WITHOUT GLASSES	WITH GLASSES	RIGHT EYE	LEFT EYE	EXTRA OCULAR MUSCLES	
					<i>20/20</i>	<i>20/20</i>	<i>n</i>	
		NEAR	WITHOUT GLASSES	WITH GLASSES	<i>20/</i>	<i>20/</i>	COLOR PERCEPTION	
							<i>Normal</i>	
EARS		CANAL	DRUM	HEARING		CANAL	DRUM	HEARING
	RIGHT	<i>n</i>	<i>n</i>	<i>n</i>		LEFT	<i>n</i>	<i>n</i>
NOSE AND THROAT	<i>n</i>							
MOUTH (INCLUDING TEETH)	<i>n</i>							
NECK	<i>No masses.</i>							
CHEST AND LUNGS	INSP. _____ IN.		EXP. _____ IN.					
			<i>Clear.</i>					
CARDIO-VASCULAR SYSTEM	PULSE RATE <i>90</i> B. P. <i>130/80</i> R. S. R. <i>No murmurs.</i>							
ABDOMEN	<i>No masses or tenderness.</i>							
INGUINAL REGION	(HERNIA, ADENOPATHY ETC.) <i>No hernia</i>					ANUS AND RECTUM	<i>n</i>	
GENITALIA	<i>n</i>					PROSTATE	<i>n</i>	
SPIRE	<i>No limited motion - normal curvature</i>							
EXTREMITIES	<i>n</i>							
NEUROLOGICAL	<i>n</i>							

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ADDITIONAL PHYSICAL FINDINGS:

LABORATORY DATA

URINALYSIS SP. GR. 1.020 ALB. Neg REACTION Ph 8 SUGAR Neg. MICRO: <u> </u>	HEMOGLOBIN SEROLOGY ADDITIONAL LABORATORY DATA:
SUMMARY OF X-RAY FINDINGS CHEST OTHER	ELECTROCARDIOGRAM

FINAL SUMMARY, COMMENTS AND RECOMMENDATIONS (LIST ALL SIGNIFICANT MEDICAL FINDINGS)

① Healthy male.

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MEDICAL CLASSIFICATION A B C D	WORK RESTRICTIONS None.
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I have discussed the examination results and the listed recommendations with the applicant.

DATE: 10-22-65 Wm. E. [Signature] M.D.