

ANNUAL PHYSICAL EXAMINATION FORM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____
 Address: _____

Date of Exam: _____
 SSN: _____
 Date of Birth: _____
 Name of Accompanying Person: _____

Sex: Male Female

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS: *(Include a Medical History Summary and Chronic Health Problems List, if available)*

CURRENT MEDICATIONS: *(Attach a second page if needed)*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Does the person take medications independently? Yes No

Allergies/Sensitivities: _____

Contraindicated Medication: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years)*: ____/____/____ Type administered: _____
 Hepatitis B: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
 Influenza (Flu): ____/____/____
 Pneumovax: ____/____/____
 Other: *(specify)* _____

TUBERCULOSIS (TB) SCREENING: *(every 2 years by Mantoux method; if positive initial chest x-ray should be done)*

Date given _____ Date read _____ Results _____
 Chest x-ray (date) _____ Results _____

Is the person free of communicable diseases? Yes No *(If no, list specific precautions to prevent the spread of disease to others)*

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: Date _____ Results _____
(women over age 18)
 Mammogram: Date: _____ Results: _____
(every 2 years- women ages 40-49, yearly for women 50 and over)
 Prostate Exam: Date: _____ Results: _____
(digital method-males 40 and over)
 Hemocult Date: _____ Results: _____
 Urinalysis Date: _____ Results: _____
 CBC/Differential Date: _____ Results: _____
 Hepatitis B Screening Date: _____ Results: _____
 PSA Date: _____ Results: _____
 Other *(specify)* _____ Date: _____ Results: _____
 Other *(specify)* _____ Date: _____ Results: _____

HOSPITALIZATIONS/SURGICAL PROCEDURES:

Date	Reason	Date	Reason

Part Two: GENERAL PHYSICAL EXAMINATION*Please complete all information to avoid return visits.*

Blood Pressure: _____ / _____ Pulse: _____ Respirations: _____ Temp: _____ Height: _____ Weight: _____

EVALUATION OF SYSTEMS

System Name	Normal Findings?	Comments/Description
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mouth/Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Head/Face/Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breasts	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Abdomen	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastrointestinal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Integumentary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal/Urinary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reproductive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lymphatic	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nervous System	<input type="checkbox"/> Yes <input type="checkbox"/> No	
VISION SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No
HEARING SCREENING	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is further evaluation recommended by specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Comments:Medical history summary reviewed? Yes NoMedication added, changed, or deleted: *(from this appointment)* _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: *(include need for lab work at regular intervals, treatments, therapies, exercise, hygiene, weight control, etc.)* _____Recommendations for manual breast exam or manual testicular exam: *(include who will perform and frequency)* _____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency: _____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)*: No Yes *(specify)* _____Does this person use adaptive equipment? No Yes *(specify)*: _____Change in health status from previous year? No Yes *(specify)*: _____This individual is recommended for ICF/ID level of care? *(see attached explanation)* Yes NoSpecialty consults recommended? No Yes *(specify)*: _____Seizure Disorder present? No Yes *(specify type)*: _____ Date of Last Seizure: _____Name of Physician *(please print)* _____

Physician's Signature _____

Date _____

Physician Address: _____

Physician Phone Number: _____