ANNUAL PHYSICAL EXAMINATION FORM

Please complete all information to avoid return visits.

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ SSN: _____

_____ Date of Birth: _____

Sex: ☐Male ☐Female Name of Accompanying Person: _____

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: *(women over age 18)* **Date** _____ **Results** _____

Mammogram: *(every 2 years- women ages 40-49, yearly for women 50 and over)* **Date:** _____ **Results:** _____

Prostate Exam: *(digital method-males 40 and over)* **Date:** _____ **Results:** _____

Hemoccult **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

Name: _____ Date of Exam: _____

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	☐Yes ☐No	
Ears	☐Yes ☐No	
Nose	☐Yes ☐No	
Mouth/Throat	☐Yes ☐No	
Head/Face/Neck	☐Yes ☐No	
Breasts	☐Yes ☐No	
Lungs	☐Yes ☐No	
Cardiovascular	☐Yes ☐No	
Extremities	☐Yes ☐No	
Abdomen	☐Yes ☐No	
Gastrointestinal	☐Yes ☐No	
Musculoskeletal	☐Yes ☐No	
Integumentary	☐Yes ☐No	
Renal/Urinary	☐Yes ☐No	
Reproductive	☐Yes ☐No	
Lymphatic	☐Yes ☐No	
Endocrine	☐Yes ☐No	
Nervous System	☐Yes ☐No	
VISION SCREENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No
HEARING SCREENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No

Additional Comments:

Medical history summary reviewed? ☐**Yes** ☐**No**

Medication 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** ☐**No**

Specialty 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:** _____