# 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:_____ 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)*

| |
|---|
| |
| |
| |
| |

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

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

| Medication Name | Dose | Frequency | Diagnosis | Prescribing Physician Specialty | Date Medication Prescribed |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**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)*

**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:** _____

**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, include specifics for medical diet** *(for example low salt)* **and/or orders for food/liquid modification** *(for example: mechanical soft with nectar thick liquids)* _____

**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**

**This individual is recommended for ICF/ORC 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:** _____