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: ______________________

12/11/09, revised 4/4/13