

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: _____

Sex: ☐ Male ☐ Female

Date of Birth: _____

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: 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	☐ 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 ☐ 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: _____