

# 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: <i>(women over age 18)</i>	Date: _____	Results: _____
Mammogram: <i>(every 2 years- women ages 40-49, yearly for women 50 and over)</i>	Date: _____	Results: _____
Prostate Exam: <i>(digital method-males 40 and over)</i>	Date: _____	Results: _____
Hemoccult	Date: _____	Results: _____
Urinalysis	Date: _____	Results: _____
CBC/Differential	Date: _____	Results: _____
Hepatitis B Screening	Date: _____	Results: _____
PSA	Date: _____	Results: _____
Other <i>(specify)</i> _____	Date: _____	Results: _____
Other <i>(specify)</i> _____	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	<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  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: