

ANNUAL PHYSICAL EXAMINATION FORM

Date of Exam: _____

A. General Information

Patient _____ DOB _____

Ht _____ Wt _____ Temp _____ BP _____

Sex: Male Female

B. Diagnosis/ Significant Health Conditions

Health/ Medical _____

Cognitive _____

Psychiatric _____

Other _____

C. Immunization/ Communicable Disease

Date of last Tetanus/Diphtheria: _____

Date of last Tuberculosis (TB) Screening: _____ Results: _____

Chest x-ray (date): _____ Results: _____

Influenza (Flu): _____ Other: *(specify)* _____

Is the person free of communicable diseases? Yes No

If "No", describe _____

D. History of Hospitalization, surgery, and major medical issues during the past year

E. Physical Examination

| Area | Typical | Atypical | Comments |
|----------------|---------|----------|----------|
| HEENT | | | |
| Respiratory | | | |
| Cardiovascular | | | |
| Incontinence | | | |
| Genito-Urinary | | | |
| Abdominal | | | |
| Skeletal | | | |
| Skin | | | |
| Extremities | | | |
| Mental Status | | | |

F. Laboratory Data

| Type | Date | Results |
|---------------------------|------|---------|
| Urinalysis | | |
| HGB/HCT | | |
| Cholesterol Test | | |
| Glucose Test | | |
| PAP Smear | | |
| Mammogram | | |
| Prostate Specific Antigen | | |
| Other | | |
| | | |
| | | |

G. Medications

| Name and Dosage | Schedule | Route | Purpose |
|-----------------|----------|-------|---------|
| | | | |
| | | | |
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H. Food Service and Dietary

Recommended diet and special instructions: _____

I. Adaptive or assistive equipment needs

N/A Wheelchair Walker

Other (please specify): _____

J. Limitation on activities or training

K. Treatment plan/ follow-up

L. Additional Comments

Physician's Name _____

Address _____

City, State, Zip _____

Telephone _____

Physician's Signature

Date