

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: _____

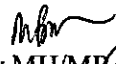
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The Southeastern Pennsylvania Health Care Quality Unit

TO: MR Directors, Residential Provider Agencies

FROM: Dina McFalls, Director 
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RE: Annual Physical Examination Form

DATE: December 14, 2009

The Annual Physical Examination Form previously forwarded in September has been amended to include additional information suggested by Residential Provider Agencies in our area. The additions include the following:

- Reminder to complete all information (appears on both sides of the form)
- Question – “Does the person take medications independently?”
- Space to include the type of tetanus vaccine administered
- Space to include hospitalizations/surgical procedures
- Question – “Does this person use adaptive equipment?” with space to list equipment

Enclosed please find a copy of the revised Annual Physical Examination Form and accompanying document (*Explanation of Intermediate Care Facility/Mental Retardation [ICF/MR] Level of Care Certification*). The Commonwealth has acknowledged that this form meets waiver certification and recertification requirements and has been endorsed by the counties in the Southeast Region of Pennsylvania.

The use of this form will foster consistency in collecting comprehensive health information while providing community health care practitioners with an instrument that is familiar among their patients with Intellectual/Developmental Disabilities (I/DD). This format was developed for an electronic record format and would help in preparing for the anticipated conversion to electronic record keeping which may be part of Federal health care reform. Your cooperation in using this form is encouraged and will be appreciated.

We are forwarding the document in both pdf and Word formats. The document will also be available on the PCHC website at <http://www.pchc.org/Documents/Forms/Forms.aspx>.

Please feel free to contact us with any questions you may have.

cc: Vicki Stillman-Toomey, Regional Program Manager, ODP

Enclosure