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HSE
Staffing Agency

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ANNUAL PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

Sex: ☐Male ☐Female Name of Accompanying Staff: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS *(Attach Lifetime Medical History Summary and Chronic Health Problems List)*

CURRENT MEDICATIONS *(Attach a second page if needed):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: _____

Contraindicated Medication: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years):* ___/___/___

Hepatitis B: ___/___/___ ___/___/___

Flu Shot: ___/___/___ **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 _____

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: **Date:** _____ **Results:** _____
(women over age 18)

Mammogram: **Date:** _____ **Results:** _____
(every 2 years- women ages 40-19, yearly for women 50 and over)

Prostate Exam: **Date:** _____ **Results:** _____
(digital method-males 40 and over)

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Hemoccult	**Date:** _____	**Results:** _____
Urinalysis	**Date:** _____	**Results:** _____
CBC/Differential	**Date:** _____	**Results:** _____
Hepatitis B Screening	**Date:** _____	**Results:** _____
PSA	**Date:** _____	**Results:** _____

Other *(specify)* _____ **Date:** _____ **Results:** _____

Part Two: GENERAL PHYSICAL EXAMINATION

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	
Endocrine	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Integumentary	☐ Yes ☐ No	
Renal/Urinary	☐ Yes ☐ No	
Reproductive	☐ Yes ☐ No	
Lymphatic	☐ 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:

Lifetime medical history summary reviewed? ☐ Yes ☐ No

Medication added, changed, or deleted *(from this appointment)*: _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: *(including need for lab work at regular intervals, exercise, hygiene, weight control, etc.)*

_____

Recommendations for manual breast exam or manual testicular exam *(who will perform; frequency)*:

_____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency:

_____

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'Free of communicable diseases? ☐ Yes ☐ No *(if no, list specific precautions to prevent the spread of disease to others)*

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)* ☐ No ☐ Yes *(specify):*

Change in health status from previous year? ☐ No ☐ Yes *(specify):* _____

Specialty consults recommended? ☐ No ☐ Yes *(specify)* _____

Seizure Disorder present? ☐ No ☐ Yes *If Yes, specify type:* _____ Date of Last Seizure: _____

Mental Retardation Diagnosis: ☐ **Yes** ☐ **No**

This individual is recommended for ICF/MR level of care *(see attached explanation).* ☐ **Yes** ☐ **No**

Name of physician *(please print)*	**Physician's Signature**	**Date**

Physician Address:_____

Physician Phone Number: _____