**ANNUAL PHYSICAL EXAMINATION FORM**

| Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT |
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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)*

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

| **Medication Name** | **Dose** | **Frequency** | **Diagnosis** | **Prescribing Physician Specialty** |  **Date Medication Prescribed** |
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**Allergies/Sensitivities:**

**Contraindicated Medication:**

IMMUNIZATIONS:

**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

**Hepatitis B Screening Date:**   **Results:**

| Part Two: GENERAL PHYSICAL EXAMINATION |
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**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:

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:

**Name of physician *(please print)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Address:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**