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:

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

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**_____