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:_____

_____ Date of Birth: _____

Sex: ❒Male ❒Female 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)

Hemoccult **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 ☐No**

Specialty 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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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