



ANNUAL PHYSICAL EXAMINATION
(Attach to Physician Visit Form and Attach Routine Orders)

Name: _____ Date of Physical: _____

Date of Birth: _____ Allergies: _____

REQUIRED INFORMATION:

Height: _____ Weight: _____ Pulse: _____ B/P: _____

Urinalysis/Results _____

TB / PPD Given or Chest X-Ray (if applicable): _____ Date Read: _____

Results: _____

Other: _____

DME CHECK: Please indicate if DME (wheelchair/walker/braces) is in need of maintenance services

Device (wheelchair, walker, braces): _____ In Working Order Maintenance Needed

REVIEW OF SYSTEMS:

	<u>Normal</u>	<u>Abnormal</u>	<u>Specify if Abnormal</u>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Nasal Pharyngeal	<input type="checkbox"/>	<input type="checkbox"/>	
Thorax / Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Musculo-Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Glandular	<input type="checkbox"/>	<input type="checkbox"/>	
Genital	<input type="checkbox"/>	<input type="checkbox"/>	
Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary Tract	<input type="checkbox"/>	<input type="checkbox"/>	
Anorectal	<input type="checkbox"/>	<input type="checkbox"/>	

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NAME: _____

DIAGNOSIS AND IMPRESSION OF HEALTH (include ICD.10 code with diagnosis):

MISCELANEOUS:

	<u>YES</u>	<u>NO</u>	<u>If no, specify</u>
Is free of communicable disease	<input type="checkbox"/>	<input type="checkbox"/>	
May receive regular diet	<input type="checkbox"/>	<input type="checkbox"/>	
May continue full activity without restrictions	<input type="checkbox"/>	<input type="checkbox"/>	
Does not require professional nursing services except on a PRN basis	<input type="checkbox"/>	<input type="checkbox"/>	
This individual may consume alcoholic beverages at supervised social gatherings (if yes, specify limits)	<input type="checkbox"/>	<input type="checkbox"/>	

RECOMMENDATIONS FOR: (Box will be checked if person is currently receiving services. Check YES or NO and specify recommendations if interested in initiating or continuing services)

	<u>YES</u>	<u>NO</u>	<u>If no, specify</u>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Audiological Evaluation	<input type="checkbox"/>	<input type="checkbox"/>	

OTHER:

PRESCRIBED MEDICATION / TREATMENT ORDERS: (Note: Psychotropic medications cannot be "PRN". [CSPR #00-7-91/Section 16.624g] Unless otherwise specified, all medications / treatments are good for 180 days.)

	<u>CONTINUE</u>	<u>D/C</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

Signature: _____ **Date:** _____
(Your signature indicates you have informed the patient of his / her condition.)

Printed Name