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:

	Normal	Abnormal	Specify if Abnormal
Skin	☐	☐	
Head	☐	☐	
Eyes	☐	☐	
Vision	☐	☐	
Ears	☐	☐	
Hearing	☐	☐	
Nasal Pharyngeal	☐	☐	
Thorax / Lungs	☐	☐	
Breasts	☐	☐	
Cardiovascular	☐	☐	
Abdomen	☐	☐	
Musculo-Skeletal	☐	☐	
Neurological	☐	☐	
Glandular	☐	☐	
Genital	☐	☐	
Pap Smear	☐	☐	
Urinary Tract	☐	☐	
Anorectal	☐	☐	

ANNUAL PHYSICAL EXAMINATION

NAME: _____

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

_____

_____

_____

MISCELANEOUS:

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

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)

	YES	NO	If no, specify
☐ Physical Therapy	☐	☐	
☐ Occupational Therapy	☐	☐	
☐ Audiological Evaluation	☐	☐	

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.)

	CONTINUE	D/C
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

Signature: _____ **Date:** _____

(Your signature indicates you have informed the patient of his / her condition.)

_____

Printed Name