Circle of Support, Inc.

Annual Physical Examination Form

NAME _____ **DATE**_____

Address _____ **Telephone #** _____
(street /city /state/zip code)

Date of Birth _____ **Status** _____

CURRENT MEDICATIONS (Name/Dosage/Frequency)

Name	Dosage	Frequency	Reason

***Are there any side effects observed?** ☐ **Yes** ☐**No**

***If yes, describe:** _____

***Has the benefits and side effects of the medication(s) been reviewed?** ☐ **Yes** ☐**No**

VITAL SIGNS: Blood Pressure _____ Heart Rate _____ Respiration _____
Height _____ Weight _____ Temperature_____

Allergies: _____

MEDICAL HISTORY

_____

_____

_____

PHYSICAL FINDINGS

	N	A	R	Comments		N	A	R	Comments
Head					**Heart**				
Eyes					**Abdomen**				
Ears					**Genitals**				
Nose					**Rectal**				
Throat					**Extremities**				
Lymph Nodes					**Skin**				
Mouth/Teeth					**Feet/Nails**				
Neck					**Bones/Joints/Muscles**				
Chest					**Neuro**				
Breasts					**Psych**				
Lungs					**Other**				

Key: N= Normal A= Abnormal R=Refused/Not Evaluated

Hearing: Normal _____ Abnormal/Needs further evaluation _____

Vision: Normal _____ Abnormal/Needs further evaluation _____

Speech/Language: Normal _____ Impaired/Needs further evaluation _____

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DIAGNOSES

_____

_____

_____

IMMUNIZATION STATUS / TESTS/MEASUREMENTS

Tetatus Toxoid Date: _____(Every 7-10 years) Influenza, Date: _____

Hepatitis B: 1st _____ 2nd _____ 3rd _____ TB Test: Positive _____ Negative _____

FURTHER EVALUATION REQUIRED:

Psychological	___ Yes___ No	Psychiatric	___ Yes ___No
Dental	___Yes ___ No	PT	___Yes ___ No
Nutritional	___ Yes___ No	OT	___Yes ___ No

Lab Work _____
X-Ray _____

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NOTE: Kindly answer the following:

1. Can the individual actively participate in a developmental training program (Vocational, personal/social, supported employment, competitive employment) Yes ____ No ____

If No, please explain:_____

2. What working conditions/situations or recreational activities have to be avoided?

_____

_____

3. Is the individual free from any communicable disease? Yes ____ No ____

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PHYSICIAN'S ORDER:

_____ Individual to self-administer medications independently.

_____ Individual to participate in a self-administration of medication training program

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FOLLOW-UP DATE: _____

_____ _____

Signature **Date**

_____ _____

Printed Name **Telephone Number**

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