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

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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:** ______________________

Ds Virtual Urgent Care Primary Care,
Weight loss and IV Vitamins
Healthy life healthy body