Annual Physical Exam Form

This form may be emailed to FamilyTouchReporting@gmail.com

Individual's Name: ____________________ DOB: __________ Date of Exam: ______________

Medical Professional Name: ____________________ Position / Title: ______________

Location: Facility Name: ____________________ Phone Number: __________

Address: ____

PHYSICAL HEALTH ASSESSEMENT

Vision:	☐ Normal	☐ Needs further evaluation
Hearing:	☐ Normal	☐ Needs further evaluation
Skin Integrity:	☐ Normal	☐ Needs further evaluation

Vitals:

Weight: ____ Height: ____

Blood Pressure: ____

Pulse: ____ O2: ____

Female Preventive Screening Needs:		Male Preventive Screening Needs:	
☐ Pelvic & Breast Exam	________ (next due date)	☐ Testicular Exam	________ (next due date)
☐ Mammogram	________ (next due date)	☐ Prostate Exam	________ (next due date)

All medications reviewed for purpose & possible interactions: ☐ Yes ☐ No ☐ N/A

Lab work needed: ☐ Yes ☐ No ____________________ (Specify)

Seasonal vaccinations recommended: ☐ Yes ☐ No ____________________ (Specify)

Other vaccinations recommended: ☐ Yes ☐ No ____________________ (Specify)

Follow-up visit requested: ☐ Yes ☐ No If yes, when: ____________________

Summary of Visit: ____

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Medical Professional Signature: ____________________

Attending Provider: ____________________ Attending Parent / Guardian: ____________________

PLEASE BRING A CURRENT LIST OF MEDICATIONS TO ALL MEDICAL APPOINTMENTS (04/2020)