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:

☐ Pelvic & Breast Exam _____ (next due date)

☐ Mammogram _____ (next due date)

Male Preventive Screening Needs:

☐ Testicular Exam _____ (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: _____

_____

_____

_____

Medical Professional Signature: _____

Attending Provider: _____ Attending Parent / Guardian: _____

PLEASE BRING A CURRENT LIST OF MEDICATIONS TO ALL MEDICAL APPOINTMENTS

(04/2020)