Chanan Foundation Annual Physical

Individual Information:

Full Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Phone:** _____

Address: _____

Legal Status (Circle One): **Competent** **Adjudicated Incompetent** **Minor**

Legal Guardian/Emergency Contact:

Name and phone: _____

Legal Guardian? Y N **Relationship:** _____

Current Health Information:

Known Allergies:

_____

_____

_____

Current Diagnoses:

_____

_____

_____

_____

_____

_____

_____

_____

Hospitalizations, Surgeries, and Major Illnesses: (Reason and date)

_____

_____

_____

_____

_____

Current Support Needs for ADL's:

Ambulation	Independent	Supervision	Assistance	Total Care
Bathing	Independent	Supervision	Assistance	Total Care
Dressing	Independent	Supervision	Assistance	Total Care
Eating	Independent	Supervision	Assistance	Total Care
Toileting	Independent	Supervision	Assistance	Total Care
Communication	Independent	Supervision	Assistance	Total Care

Page 1 completed by: _____ **Date:** _____

General Physical Examination:

Weight: _____ **Height:** _____ **Blood Pressure:** _____ **Pulse:** _____

Respirations: _____ **Temperature:** _____ **Other (Specify):** _____

	Normal Findings?		Comments
Eyes	**Yes**	**No**	
Ears	**Yes**	**No**	
Nose	**Yes**	**No**	
Mouth/Throat	**Yes**	**No**	
Head/Face/Neck	**Yes**	**No**	
Lungs/Chest/Breasts	**Yes**	**No**	
Skin/Lymph Nodes	**Yes**	**No**	
Cardiovascular	**Yes**	**No**	
Abdomen	**Yes**	**No**	
Gastrointestinal	**Yes**	**No**	
Musculoskeletal	**Yes**	**No**	
Neurological	**Yes**	**No**	
Respiratory	**Yes**	**No**	
Motor Function/ Extremities	**Yes**	**No**	

New/Changed Diagnosis: _____

Medication Changes Today: _____

Dietary Restrictions (calorie-restricted, ADA, low sodium, etc.): _____

_____

Choking Risk:

Minimal Risk/Regular Diet Low Risk/Bite-Size Diet Moderate Risk/Chopped Diet
High Risk/Ground Diet Pureed/Individual Swallow Precautions (Attach specific precautions)_____

Change in Overall Health from Previous Year? **No** **Yes (Specify):** _____

_____

Is the person free of communicable diseases? **Yes** **No (Specify with precautions to prevent the spread of disease to others):** _____

_____

Can this person be cared for in a non-clinical setting (Personal Care Home/Community Living Arrangement? **Yes** **No**

Physician/Clinician Printed Name: _____ **Date:** _____

Signature: _____

PRN Orders - (Generic substitution permissible) **Individual:**

Health Care Providers may add, substitute, or remove treatments.

Oral Medications:

Allergies: ***Zyrtec/ Cetirizine 10 mg***; 1 tablet once daily, as needed for onset of seasonal allergies.

Colds: ***Mucinex 600 mg***, 1 tablet every 12 hours, as needed.

Congestion/ Cough: ***Robitussin DM cough syrup***, 2 teaspoons every 4 hours, as needed.; ***Cough drops/lozenges.***

Constipation: ***Milk of Magnesia liquid*** , 30 mL per package directions, at bedtime with a full glass of water on the 3rd day without a bowel movement;

Magnesium Citrate, follow package directions on the 4th day without a bowel movement.

Diarrhea : ***Imodium AD tablets (or liquid,),*** per package directions. Do not exceed 4 doses in a 24 hour period.

Fever/Pain: ***Tylenol 500 mg***, 2 tablets every 4-6 hours, as needed. or

Ibuprofen 200mg, 2 tablets every 4-6 hours with food, as needed.

Heartburn/

Stomach Upset: ***Pepto Bismol tablets (or liquid, as tolerated),*** per package directions. Do not exceed 8 doses in a 24 hour period.

Sore Throat: ***Cough drops/ lozenges,*** per package directions.

Treatments/Topicals:

Eye Irritation: ***Visine***, 1-2 drops in affected eye(s) up to 4 times daily. Notify the physician if there is no improvement.

Excessive Ear Wax: ***Debrox Earwax Removal Kit:*** per package directions. If the problem persists after 4 days, notify physician.

Hives/Itching: ***Hydrocortisone cream 1%***, apply a thin layer to the affected area 2-3 times daily.

Insect Repellant: ***Insect Repellant of Choice (22% DEET)***, apply topically per package directions.

Muscle Aches: ***Ben-Gay or Aspercreme***, apply topically to affected area per package directions.

Oral Pain: ***Anbesol or Orajel***, use per package directions for gum or tooth pain. Notify dentist if pain persists.

Sun Exposure: ***Sunscreen of choice (SPF 30 or greater)***, apply topically to exposed areas when sun exposure is expected to be prolonged and/or during the hours of noon to 4pm.

Physician/Clinician Printed Name: **Date:**

Signature: