Lifestyles for the Disabled

Annual Physical Examination

INDIVIDUAL: _____ DOB: _____ Date: _____

A medical examination is required to be completed by a licensed physician, as is medically necessary, to meet health needs and to ensure fitness to participate in agency activities. Please notify the agency if the individual has any changes to medication regimens and/or significant medical events that would change his/her ability to participate in activities. **Please submit a copy of the individual's vaccination records**

PHYSICAL EXAMINATION

Diagnosis: _____

HT:	**WT:**	**B/P:**
T:	**P:**	**R:**

HEAD		**GYN**	
EYES		**PAP**	
ENT		**SKIN**	
NECK		**CNS**	
CARDIO		**MUSCULOSKELETAL**	
PULMO		**EXTREMITIES**	
ABD		**G/U**	

LABS/DIAGNOSTICS/VACCINATIONS

TEST	RESULT	DATE	TEST	RESULT	DATE
PPD			**HEP B SCREEN**		
CXR			**HEP B VACC**		
TD BOOSTER			**PNEUMOVACC**		
HGB			**U/A**		

Other: _____

Surgical Procedures: _____

Chronic Recurring Illness: _____

○ **PLEASE CHECK IF THE INDIVIDUAL DOES NOT TAKE MEDICATION.**

MEDICATION	DOSAGE	FREQUENCY	ROUTE	TIME	REASON FOR MEDICATION

For any medications, including OTC/PRN, please include copies of the prescriptions with this form.

ALLERGIES

DRUG/REACTION	FOOD/REACTION	ENVIRONMENTAL/REACTION

Individual: _____ Date:_____

DIET Order: _____

RESTRICTIONS: _____

CONSISTENCIES

SOLIDS (CHECK 1)		LIQUIDS (CHECK 1)	
WHOLE- NO MODIFICATIONS		THIN LIQUIDS	
1 INCH PIECES		NECTAR THICK	
½ INCH PIECES		HONEY THICK	
¼ INCH PIECES		PUDDING THICK	
GROUND			
PUREED			

ADAPTIVE EQUIPMENT (EYEGLASSES, DENTURES, HEARING AIDS, ETC.)

LIST:

_____

ADDITIONAL RISK FACTORS

LIST:

_____

RESTRICTIONS WHILE IN PROGRAM

SWIMMING/DIVING USE OF STAIRS STRENUOUS ACTIVITIES OTHER: _____

PLEASE CIRCLE ANY ADDITIONAL RISK FACTORS:

OBESITY	CVO/CAD	HYPOTENSION
DIABETES	PVD/CLAUDICATION	HYPOGLYCEMIA
SYNCOPE	ARRHYTHMIA	CATARACTS
COPD/ASTHMA	SEIZURES	OTHER: _____
CHF/MYOPATHY	HYPERTENSION	

COMMENTS:_____

_____

SPECIAL NOTES: _____

_____

PHYSICIAN SIGNATURE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

DEA# OR STAMP