DDD SERVICE COORDINATION
PHYSICAL EXAMINATION REPORT

Name: _____ **Date of Birth**: _____

Allergies: _____

Medications: _____

_____

_____

Date of exam: _____ **Physician**: _____

Address: _____ **Phone**: _____

Insurance numbers: _____

PHYSICIAN'S REPORT

Pulse: _____ Respiration: _____ B/P: _____ Height: _____ Weight: _____

EXAM	NORMAL		ABNORMAL – Comments/Test Results
Head			
Eyes			
Ears			
Extremities			
Mouth & Throat			
Neck			
Chest			
Heart			
Lungs			
Abdomen			
Pelvic			
Rectal			
Ability to hear			
Ability to see			

Laboratory:

HGB: _____ HCT: _____ WBC: _____ Pap: _____ Cholesterol: _____ Other: _____

UA: S/A, Micro: _____ Prostate exam completed: _____ *Yes* _____ *No*

Mammogram ordered: _____ *Yes* *Date*: _____ *No* _____

Psychoactive/Anticonvulsant Drug Level: _____

Date of most recent tetanus shot: _____

Immunizations given this visit: _____

Are nutritional needs adequately met? _____ *Yes* _____ *No*
(comment and include specific diet recommendations & target weigh)

Medication changes:

May use Non-Prescription medications according to directions? _____ *Yes* _____ *No*
Limitations:

Diagnosis:

Recommendations:

Should not participate in:
_____ Running _____ Water sports _____ Hiking _____Contact sports _____ Other

May participate in Special Olympics: _____ *Yes* _____ *No*
Other Comments:

Next completed physical should
be completed in _____ years.

_____
(Physician's Signature)

_____
(Date Signed)

Copies: Original to SC file Provider-Day_____ ( ) Provider-Res_____ ( )