HARVEY-MARION COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION

REVISION DATE: 5-21-18 FAX#: 316-283-7969

PHYSICAL EXAMINATION FORM

PART 1: COMPLETED BY APPLICANT (DOCTOR: PLEASE VERIFY)

NAME: _____ **BIRTH DATE:**_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK):

- ❑ FREQUENT HEADACHES
- ❑ DIFFICULTY WITH VISION
- ❑ DIFFICULTY WITH HEARING
- ❑ CONVULSIONS OR SEIZURES (FREQUENCY_____)
- ❑ UNUSUAL IRRITABILITY
- ❑ DIFFICULTY WITH MEMORY
- ❑ CHOKING ON FOOD/FLUID
- ❑ FAINTING
- ❑ UNUSUAL WEIGHT GAIN/LOSS
- ❑ DIARRHEA OR CONSTIPATION
- ❑ LOSS OF APPETITE
- ❑ HEMORRHOIDS
- ❑ FREQUENT INDIGESTION
- ❑ HERNIA OR "RUPTURES"
- ❑ VARICOSE VEINS OR LEG ULCERS
- ❑ FEVER OR NIGHT SWEATS
- ❑ COUGH PRODUCING BLOOD
- ❑ PERSISTENT COUGHING
- ❑ TUBERCULOSIS
- ❑ EXCESSIVE FATIGUE
- ❑ PAIN IN CHEST
- ❑ SHORTNESS OF BREAT
- ❑ ASTHMA OR HAY FEVER
- ❑ SWOLLEN ANKLES
- ❑ PAIN IN CHEST
- ❑ SHORTNESS OF BREATH
- ❑ ASTHMA OR HAY FEVER
- ❑ SWOLLEN ANKLES
- ❑ ARTHRITIS/SWOLLEN JOINTS
- ❑ PERSISTENT/ RECURRING SKIN RASHES/LESIONS
- ❑ BURNING UPON URINATION
- ❑ BLOOD IN URINE

- ❑ NERVOUS BREAKDOWN
- ❑ HEART ATTACK
- ❑ STROKE
- ❑ SEXUALLY TRANSMITTED DISEASES
- ❑ DIABETES
- ❑ HYPOGLYCEMIA
- ❑ HEPATITIS
- ❑ BED WETTING
- ❑ PMS
- ❑ FRACTURES (DESCRIBE/DATE)_____
  _____
- ❑ OPERATIONS (DESCRIBE/DATE)
  _____
  _____
  _____
  _____
- ❑ OTHER HOSPITALIZATIONS (DESCRIBE/DATE)
  _____
  _____
  _____
- ❑ SERIOUS INJURIES (DESCRIBE/DATE)_____
  _____
  _____
- ❑ FOOD ALLERGIES (SPECIFY)_____
  _____
  _____
- ❑ DRUG ALLERGIES (SPECIFY)_____
  _____
  _____

PART 2. COMPLETED BY PHYSICIAN.
LAB/IMMUNIZATION RECORD (GIVE LAST DATE FOR EACH, ATTACH LAB WORK WHEN POSSIBLE):

TB TEST: / / ☐ NEGATIVE ☐ POSITIVE		BLOOD WORK: / / ☐ CBC ☐ SMAC ☐ VDRL	
CHEST X-RAY (NECESSARY ONLY FOR POSITIVE TB OR THOSE UNABLE TO TAKE TB TEST) ☐ NEGATIVE ☐ POSITIVE		HEPATITIS B: / / ☐ NEGATIVE ☐ POSITIVE	
TETANUS:	MUMPS:	MEASLES:	RUBELLA:
POLIO:	DPT/DT:	U/A:	OTHER:
IS PATIENT NOW UNDER YOUR CARE OR ANY OTHER PHYSICIAN? ☐ YES ☐ NO			
IF YES, GIVE NATURE OF CONDITION AND PLAN FOR TREATMENT:			

PHYSICAL EXAMINATION (DEVIATIONS FROM NORM SHOULD BE DESCRIBED:)

HEIGHT: ____ ft. ____ in. WEIGHT: _____lbs.	TEMPERATURE: _____ f
BLOOD PRESSURE:	PULSE:
VISION: _____ right _____ left OTHER FINDINGS:	

HEARING: _____ right _____ left OTHER FINDINGS:	
NOSE:	THROAT:
MOUTH:	NECK:
LYMPHATIC SYSTEMS:	BREASTS:
LUNGS: _____ right _____ left	CARDIOVASCULAR SYSTEM:
ABDOMEN:	HERNIA:
GENITO-URINARY:	ANO-RECTAL:
NERVOUS SYSTEM:	SKIN:
FEET:	VARICOSE VEINS:

DIAGNOSIS	ICD CODE
1_____	1_____
2_____	2_____
3_____	3_____
4_____	4_____
5_____	5_____

DO YOU HAVE KNOWLEDGE OF SUBSTANCE ABUSE BY THIS INDIVIDUAL? ☐ YES ☐ NO

PROGNOSIS:

IS THE PATIENT'S CONDITION EXPECTED TO EXHIBIT DETERIORATION OR IMPROVEMENT? EXPLAIN:_____
_____

ACTIVITIES TO BE AVOIDED:	WEIGHT RESTRICTIONS:

ADAPTIVE DEVICES: WHAT DEVICES ARE USED AND WHEN ARE THEY NEEDED? _____
_____

LIST ALL MEDICATIONS, NON-PRESCRIPTION AND PRESCRIPTION, CURRENTLY BEING TAKEN BY THIS PERSON

MEDICATION	PRESCRIBING DR.	PURPOSE	DOSAGE	FREQUENCY
1_____	1_____	1_____	1_____	1_____
2_____	2_____	2_____	2_____	2_____
3_____	3_____	3_____	3_____	3_____
4_____	4_____	4_____	4_____	4_____
5_____	5_____	5_____	5_____	5_____
6_____	6_____	6_____	6_____	6_____

RECOMMENDATIONS/COMMENTS:
_____
_____

PHYSICIAN'S SIGNATURE: _____ DATE:_____
PHYSICIAN'S PRINTED NAME: _____
PHYSICIAN'S ADDRESS AND PHONE NUMBER: _____