

Annual Physical Examination

Date of Examination: _____

Individual's Name _____ DOB _____

Diagnosis/es: _____

1. Allergies (foods, drugs and environmental): _____

2. Current Routine Medications (list drug, dosage, frequency): _____

3. PRN Medications: _____

4. Immunizations current? Yes _____ No _____ Date of Tetnus booster? _____
Hepatitis B Series completed? Yes _____ No _____ Date/s: _____

5. General Appearance (nutrition, deformities, behaviors etc.): _____
Height _____
Weight _____

6. Head (shape, defects etc.): _____

7. Eyes: Iris _____ Axis _____ Vision OD 20/ _____
Fundi _____ Media _____ OS 20/ _____

8. Ear Canals: _____ Drums _____ Hearing: Right _____
Left _____

9. Nose, Mouth, Throat (abnormalities, including those of teeth, palate, toungue): _____

10. Neck (abnormalities in mobility, thyroid gland, lymph glands etc.): _____

11. Chest (abnormalities, including deformities; impaired ventilation, etc.): _____

12. Cardiovascular (note all significant abnormalities): _____
Apical Heart Rate _____ Regular? Irregular?
BP _____ R arm? L arm?
Orthostatic changes? _____

Annual Physical Examination, continued

Individual's Name _____ Date: _____

13. **Abdomen** (hernia, palpable organs, masses etc.): _____

14. **Genitalia:** _____

15. **Prostate or GYN exam with Pap:** _____

16. **Skin:** _____

17. **Muscular-Skeletal:** _____

- | | | | |
|--------------|-------|----------|-------|
| a. Strength- | _____ | d. Tone- | _____ |
| b. Posture- | _____ | e. Gait- | _____ |
| c. Bulk- | _____ | | |

18. **Neurological:** _____

- | | | | |
|---------------------|-------|-----------------|-------|
| a. Crainial Nerves- | _____ | f. Orientation- | _____ |
| b. Tendon Reflex- | _____ | g. Activity- | _____ |
| c. Sensation- | _____ | h. Speech- | _____ |
| d. Coordination- | _____ | i. Bladder- | _____ |
| e. Bowel Control- | _____ | | |

19. **Lab:** _____

- | | | | |
|----------------|----------|-------------------|-------------|
| a. Hct/Hgb- | _____ | Other Lab Values: | _____ |
| b. Urinalysis- | _____ | | |
| c. Hep B - | ab _____ | ag _____ | Date: _____ |

20. **Impression:** (Please include etiology of developmental delay, if know; limitations, ie: lifting, ambulation, vision, hearing, speech, etc.):

21. **Plan:** _____

a. Recommendations (Therapies, Diagnostic Procedures, Referrals to specialists, etc.) including **Follow up schedule:**

b. Medications (changes, concerns, etc.): _____

c. **Return for next physical exam:** One Year _____ Two Years _____

Physician Signature: _____ Printed Name: _____ Date: _____

Address: _____ Phone: _____

Thank You! Support, Inc.