PHYSICAL EXAMINATION

(Physical and Visual Exam Required Annually)

DATE:					
NAME:		**DATE OF BIRTH:**		**AGE:**	
ADDRESS:		**TELEPHONE #:**			

DIAGNOSIS: Does the Physician confirm the diagnosis of Intellectual Disability and recommend an ICF/ID level of care for this individual? YES or NO (please circle)

PAST MEDICAL HISTORY : (include operations or serious injuries & dates; hospitalizations & dates; menstrual history for women)	**PRESENT MEDICAL HISTORY :** (all occurring at the moment)

ALLERGIES:

SPECIAL INSTRUCTIONS FOR INDIVIDUALS DIET:	**LIMIT/RESTRICTIONS FOR INDIVIDUALS ACTIVITIES:**

CURRENT MEDICATIONS AND DOSAGE:

CONTRAINDICATED MEDICATIONS AND REASON: (medications that are not to be taken and why)

ASSESSMENT OF NECESSARY BLOODWORK INTERVALS:

ASSESSMENT OF INDIVIDUALS HEALTH MAINTENANCE NEEDS: (i.e. exercise/weight control, hygiene practices)

HEIGHT:		**PULSE:**		**TEMP:**	
WEIGHT:		**RESP:**		**BP:**	

VISION:		**DATE:**			**HEARING:**	**DATE:**	
NORMAL		ABNORMAL			NORMAL		ABNORMAL	

MEDICAL	**DATE**	**NORMAL**	**ABNORMAL**	**DESCRIBE ABNORMALITY**
Skin				
Eyes				
Ears/Nose				
Mouth/Throat				
Neck/Glands				
Lungs				
Cardiovascular				
Abdomen				
Genitalia/Breast				
Anal/Rectal				
Extremities				

GYNECOLOGICAL EXAMINATION

(Gynecological, Breast & Pap test are required annually for women over 18 years of age, unless otherwise specified by the physician)

	DATE	NORMAL	ABNORMAL	FINDINGS
PAP TEST				
BREAST EXAM				
GYN EXAM				

MAMMOGRAM **DATE:**

(Required every 2 years for women ages 40 to 49 and yearly for women age 50 and older)

	NORMAL	ABNORMAL	FINDINGS
MAMMOGRAM			

PROSTATE EXAMINATION **DATE:**

(required annually for men 40 yrs. Of age & older)

	NORMAL	ABNORMAL	FINDINGS
PROSTATE			

MANTOUX (required every two years, line test is not acceptable)

TEST DATE: PREVIOUS:

LOT # PLACED:

READ DATE:

☐ Positive ☐ Negative

CHEST X-RAY: (positive mantoux: once only) DATE OF X-RAY:

Tdap (required every 10 years)

Previous:

Current:

HEPATITIS B SCREENING **DATE:**

HBsAG ☐ Positive ☐ Negative

Carrier ☐ Yes ☐ No

Anti-HBs ☐ Positive ☐ Negative

Anti-HBc ☐ Positive ☐ Negative

HEPATITIS B INNOCULATION DATES

1 2 3

COMPLETE THIS SECTION FOR INDIVIDUALS 17 YEARS OF AGE OR YOUNGER

	Age	Date	DPT	AGE	Date	TOPV	DATE
Measles Vac			Diphtheria	2 mos		Trivalent	
Mumps Vac			Pertussis	4 mos		Oral	
Rubella Vac			Tetanus	6 mos		Polio	
				Booster		Virus	
				Booster		Vaccine	

CONTRAINDICATED IMMUNIZATIONS: (immunizations that are not to be administered and why)

FREE FROM COMMUNICABLE DISEASES

YES ☐ NO ☐

IF NO, LIST SPECIFIC PRECAUTIONS TO PREVENT TRANSMISSION

PLEASE LIST ANY RECOMMENDATIONS FOR FURTHER MEDICAL TEST OR EXAMINATIONS

Physician Signature Date Printed Name of Physician

Physician Address Telephone number