PHYSICAL EXAMINATION

(Physical and Visual Exam Required Annually) **DATE:**

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

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

PAST MEDICAL HISTORY :	**PRESENT MEDICAL HISTORY :** (all occurring at the moment)

MEDICAL TREATMENT PERTINENT TO DIAGNOSIS? (Include treatment in case of emergency)

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

TEST DATE:

READ DATE:

NOT INDICATED:

Please mark if not performed during annual physical

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