

HOPEWELL (440) 693-4074
ANNUAL PHYSICAL FORM
 Complete prior to intake and annually

| | | | | | |
|---|----|--|---------------|--------------------------|--|
| Patient Name: | | Sex: M F Age | Date of Birth | Hopewell Pin# | |
| Home Address: | | City: | St.: | Zip: | Home Phone: |
| Personal Physician: | | Address: | | Phone: | |
| HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING: | | | | | |
| YES | NO | CHECK EACH ITEM | YES | NO | CHECK EACH ITEM |
| | | Dizziness, fainting, fit or seizure | | | Heart attack or coronary disease |
| | | Frequent headaches or migraines | | | Disc disease, ruptured disc, or sciatica |
| | | Head injury or stroke | | | Abnormal electrocardiogram |
| | | Eye trouble (except glasses or contacts) | | | High or low blood pressure |
| | | Sinusitis, hay fever, or asthma | | | Communicable diseases |
| | | Pneumonia or breathing difficulty | | | Hernia or rupture |
| | | Chronic bronchitis or cough | | | Rectal trouble including hemorrhoids |
| | | Tuberculosis or positive TB skin test | | | Albumin, blood or pus in urine |
| | | Abnormal chest x-ray | | | Kidney or bladder trouble |
| | | Palpitations or fast heart beat | | | Venereal disease/STD's |
| | | Rheumatic fever or heart murmur | | | Bone or joint trouble |
| | | Pain, pressure or tightness in chest | | | Fracture or broken bone |
| | | | | | Arthritis or bursitis |
| | | | | | Any other medical problems |
| Normal | | Physical Examination | Abnormal | Height: | Weight: |
| | | General Appearance | | Blood pressure: | Heart Rate: |
| | | Eyes | | Resp. Rate: | |
| | | Ears | | Notes on Physical | |
| | | Nose, sinuses | | | |
| | | Mouth, throat | | | |
| | | Neck, thyroid | | | |
| | | Heart | | | |
| | | Lungs | | | |
| | | Abdomen | | | |
| | | Hernia | | | |
| | | Genitalia | | | |
| | | Rectum/Prostate | | | |
| | | Spine | | | |
| | | Upper Extremities | | | |
| | | Lower Extremities | | | |
| | | Strength | | | |
| Summary and Recommendations (comment on all abnormal): | | | | | |
| Assessment and update on all age appropriate immunizations and vaccines? YES NO | | | | | |
| Assess for risk of Tuberculosis. Is client at high risk for TB? YES NO | | | | | |
| If yes please provide proof of two-step TB test as appropriate. | | | | | |
| Does client need any further medical follow-up? YES NO | | | | | |
| Physician's name (print) | | <u>Physician's signature:</u> | | Date: | |