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Annual Health Evaluation

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Physician's Name: _____ Date of Exam: _____

1. General Information: Sex: _____ Weight: _____ Height: _____

Blood Pressure: _____ Pulse: _____

Allergies/Medications: _____

2. Ears: _____ Nose: _____

Throat: _____

3. Eyes/Vision: _____

Current Exam Requested: _____

4. Cardiopulmonary Status: _____

5. Abdomen: _____

Specific Diet Currently Prescribed: _____

6. Genitalia: _____

7. Muscular/Skeletal: _____

8. Neurological:

9. Medications Currently Prescribed:

10. Impressions/Diagnosis:

Lab Work/Diagnostic Tests/Consult Request:

Additional Medication/Treatment Prescribed:

11. Is the patient free of communicable diseases on this date?

Recommendation:

12. May the patient participate in Special Olympics?

Restrictions:

13. Is staff supervision of medication requested?

14. Vaccinations Given (please list dates given):

TB Test: _____ TB Result: _____ Flu Shot: _____

Hep B: _____ Pneumovax: _____

MMR: _____ Rubella: _____

Tetanus/Diphtheria: _____ Other: _____

Physician Signature: _____

Date: _____