Ardmore Enterprises, Inc.

ANNUAL PHYSICAL

PAGE 1 MUST BE COMPLETED PRIOR TO PHYSICAL EXAMINATION.

IDENTIFICATION

Last Name　First Name　Middle　Date of Birth

Address – Street　City/County　State　Zip code

Telephone Number　Race　Sex　Marital status

HEALTH HISTORY OF PAST YEAR

___________ Serious head injury
___________ Difficulty with vision
___________ Wears glasses
___________ Frequent nose bleeds
___________ Ear infections
___________ Dental extractions
___________ Sore, bleeding gums
___________ Frequent sore throats
___________ Frequent colds
___________ Pneumonia/bronchitis
___________ Hernia
___________ Varicose/veins/ulcers
___________ Psychiatric disorder
___________ Unsteadiness in walking
___________ Diabetes
___________ Asthma
___________ Heart trouble
___________ High blood pressure
___________ Severe indigestion
___________ Frequent vomiting
___________ Constipation
___________ Frequent diarrhea
___________ Bowel incontinence
___________ Urine incontinence
___________ Kidney disease
___________ Gynecology problems
___________ Venereal disease
___________ Arthritis
___________ Fractures of extremities
___________ Seizures
___________ Unusual weight loss
___________ Unusual weight gain

Other: ____

Hospitalizations/operations. Provide dates, location, and reason:

Accidents/injuries Provide dates and description:

Medications and dosages at time of physical examination (use back of page if needed):

Medication	Dosage	Prescribing Physician

Signature and title of person completing this form　Date

SEE OTHER SIDE

PHYSICAL EXAMINATION FORM (upon admission to program, and annually)

Name: ______________________________ Date: ________________

General Appearance ________________________ Nutritional status ___________________

Blood pressure __________ Weight ________________ Height ________________

T __________ P ________________ R ________________

Eyes: vision screening

Right __________________ Left ___________________ Test used ________________

Conjunctiva _____________ Sclera __________________ Cornea _________________

Pupils __________________ Lens ___________________ Fundi __________________

Ears: auditory acuity

Right __________________ Left ____________________ Bilateral ________________

Canals _________________ Drums __________________ Test used ________________

General Physical

Head ________________________________

Skin _________________________________

Nose ________________________________

Mouth _______________________________

Teeth ________________________________

Pharynx ______________________________

Neck ________________________________

Thyroid gland __________________________

Lymph nodes __________________________

Chest ________________________________

Lungs _______________________________

Heart ________________________________

Peripheral Pulses ______________________

Breasts________________________________

Abdomen ______________________________

Genitalia ______________________________

Hernia ________________________________

Rectal ________________________________

Extremities _____________________________

DTR __________________________________

Pathological reflexes ____________________

Muscle strength _________________________

Gait __________________________________

Tone __________________________________

Involuntary movements __________________

Joints _________________________________

Spine (curvatures) _______________________

Tardive dyskinesia (perform screening on attached scale). To be completed if client is receiving behavior modifying drugs at the time of examination, or in the past year.

IMPRESSION:

DIAGNOSIS:

RECOMMENDATIONS:

Signature & title of individual performing examination and completing form Date