Northern Human Services

Annual Physical Examination

To be completed by prescribing practitioner.

Date: ______________ **Person accompanying patient:** ______________________________

Name: ______________________________ DOB: ____________________

Address: ____

Allergies: ______________________________ Diet: ______________________________

Immunizations up-to-date? ☐ Yes ☐ No ______________________________

Please note any changes: ____

Height:		Weight:		BP:		Pulse:		Respiration:	

Check Each Line:	**Normal**	**Abnormal**	**Comments**
Skin	☐	☐	
Head	☐	☐	
Eyes	☐	☐	
Ears	☐	☐	
Nose/throat	☐	☐	
Mouth/Teeth/Gums	☐	☐	
Neck	☐	☐	
Chest/Breasts	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Abdomen	☐	☐	
Liver/Kidneys	☐	☐	
Prostate/Genitalia	☐	☐	
Rectum	☐	☐	
Extremities	☐	☐	
Asthma/Wheezing	☐	☐	
Other	☐	☐	

Diagnosis/Medical Issues *(please list all)* ______________________________

Date: ____________

Patient: ________________________________

Activity Level:

Activity:	**Restrictions** Yes	No	**Note any functional change since last exam:**
PT/OT Referral	☐	☐	
Swimming	☐	☐	
Group Exercise Program	☐	☐	
Other: ____________	☐	☐	**Adaptive Equipment Needs (Current and future):**
	☐	☐	
	☐	☐	

Lab Work: ________________________________

Other Tests: ________________________________

Explain if Standarized Health Recommendations are NOT ordered: ____________________

Medications (dosage, Route, Frequency Required**):**

________________________________ ____________

Practitioner's Signature Exam Date

____

Print Name / Credential

Original: Client Chart . Distributed by ______ date: ________ ,

Initials: ______ Service Coordinator, Copy to Home-Care Provider, Nurse Trainer, Guardian