

SHARED LIVING - ANNUAL PHYSICAL EXAM FORM

Last Name _____ First _____ DOB: _____

Address _____ Sex _____

B.P. _____ P. _____ Height _____ Weight _____

Eyes _____

Ears _____ Audiological _____
(Normal – Need Attention – Rx)

Nose _____ Throat _____
(Obstruction, Chronic Sinus) (Tonsils: Normal, Enlarged, Removed)

Mouth _____ Neck _____
(Caries, Abnormalities) Thyroid Enlarged, Nodules, etc.)

Breasts _____ Lungs _____
(Abnormalities) (abnormalities)

Heart _____
(abnormalities)

Abdomen _____ Hernias _____
(Abnormalities, Scars, etc.) (Inguinal, Abdominal)

(Male) Genito-Urinary _____ PSA TEST _____
(Urethral Discharge, Enlarged Prostate, UTI)

(Female) Gynecological _____ Pap Test _____ Mammo. _____

Ano – Rectal _____
(Hemorrhoids, Prolapse, Growths, etc.)

Varicosities _____ Musculoskeletal _____

Nervous & Emotional Evaluation _____

Allergies _____ Tetanus Booster _____ TB Screen _____

Flu- Vaccine _____ Pneumovax _____ Diet _____ Texture _____

Annual Cancer screening needed Yes _____ No _____ if needed please order _____

Restrictions for Physical/Recreational Activities: _____

Restrictions for Working Conditions: Yes _____ No _____

Resident May _____ May Not _____ participate in Special Olympics.

DIAGNOSIS: _____

MEDICATIONS MAY BE ADMINISTERED BY THE INDIVIDUAL OR SHARED LIVING PROVIDER.

NAME: _____

