Pine Habilitation And Supported Employment, Inc.

Medical Physical Examination

Date:	
Doctor:	
Name of Patient:	
DOB:	
Diagnosis:	
Allergies:	
Current Diet Disorders:	
Current Medication & Treatment Orders:	
Standing Order Med Restrictions:	

Medications (Check One):

	YES	NO
Are medications administered by staff?		
Is patient capable of taking medications without assistance?		
Is patient able to self-medicate with OTC medications?		
Are alcoholic beverages contraindicated?		

Health Concerns:

Medical Exam Information:

Temperature	
Pulse	
Resp.	
BP	
Height	
Weight	
Ideal Weight Range	

Laboratory Data: Please attach or mail copies of all results

Urinalysis:	
Bloodwork:	
Other:	

Is TB screening indicated? (Y or N)	
Date Applied:	
Location:	
Date Read:	
Results:	

Vision Screening Results:

Hearing Screening Results:

Speech / Language Problems:

Review of Systems:

Skin	
Lymph Nodes	
Right Eye	
Left Eye	
Right Ear	
Left Ear	
Nose	
Throat	
Mouth	
Neck	
Lungs	

Heart	
Abdomen	
Genito/Urinary	
Posture	
Gait	
Nervous System	
Gross Motor	
Fine Motor	
Extremities	
Physical Deformity	

Rate the Patient's Overall Health (Circle One):

Excellent Good Fair Poor

I find this patient free of communicable disease (Yes or No):

Please circle any new referrals indicated:

Vision Hearing Speech/Language Dermatology

Other (please specify):_____

Summary of Exam and Diagnosis:

Activity Limitations Advised:

Treatment Plans (new orders):

Are there any medical or physiological contraindications for the use of an emergency manual restraint?

Yes No

If yes, please give a brief description of said medical or physiological contraindication:

Please note:

1.) Your signature indicates a review and renewal of all current orders unless changes are indicated.
2.) Your signature indicates you have reviewed these findings with the patient and/or staff.
3.) Please attach prescriptions for all medication changes or call the pharmacy.
4.) Unless otherwise specified, you will be notified if patient misses or refuses two consecutive does of medication.

Physician Signature _____ Date _____

Next Appointment: _____