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PHYSICAL EXAMINATION FORM

Physician's Office Note: Please fax physician notes and current lab results to Nursing Services Fax 303-604-5431. Thank you.

CONSUMER NAME: _____ **DOB:** _____

PHYSICIAN'S NAME: _____ **SEX:** ☐MALE ☐FEMALE

DIAGNOSIS: _____

_____

DRUG/FOOD ALLERGIES: _____

HEIGHT:	WEIGHT:	PULSE:	B/P:

RECENT IMMUNIZATIONS

FLU:	TETANUS:	OTHER:
TB TEST:	HEP B STATUS:	

REVIEW OF SYSTEMS

CHECK ITEMS IN THE APPROPRIATE COLUMN	WNL	ABNORMAL	DESCRIPTION
1. SKIN			
2. LYMPHATICS			
3. HEAD, FACE, NECK, SCALP			
4. NOSE			
5. SINUSES			
6. MOUTH AND THROAT			
7. EARS Cerumen noted? ☐yes ☐no			
8. EYES Visual exam completed? ☐yes ☐no* Glaucoma test completed? ☐yes ☐no			**if no, indicate reason*
9. RESPIRATORY SYSTEM			
10. CARDIAC SYSTEM			
11. ABDOMEN AND VISCERA Hernia exam completed? ☐yes ☐no			

CHECK ITEMS IN THE APPROPRIATE COLUMN	WNL	ABNORMAL	DESCRIPTION
12. SPINE, MUSCULOSKELETAL X-ray for Kyphosis/Scoliosis ordered ☐yes ☐no Calcium supplement ordered? ☐yes ☐no			**if no, indicate reason*
13. GASTROINTESTINAL Rectal exam completed? ☐yes ☐no* Swallow evaluation needed? ☐yes ☐no			**if no, indicate reason*
14. ENDROCINE SYSTEM			
15. G-U (MALE) Prostate exam completed? ☐yes ☐no* PSA needed? ☐yes ☐no			**if no, indicate reason*
16. G-U (FEMALE) Pelvic completed? ☐yes ☐no* Pap smear completed? ☐yes ☐no* Breast exam completed? ☐yes ☐no* Mammogram needed? ☐yes ☐no OB/GYN referral needed? ☐yes ☐no			**if no, indicate reason*
17. UPPER EXTREMITIES			
18. LOWER EXTREMITIES			
19. NEUROLOGIC Neurological evaluation needed? ☐yes ☐no			
20. DENTAL ABNORMALITIES			

REFERRALS/THERAPIES NEEDED:

PRESCRIBED DIET:

I have reviewed this individual's current medication regime: ☐ **YES** ☐ **NO**

LAB WORK ORDERED

CBC: ☐done ☐needed	**SMA 12:** ☐done ☐needed	**SMA 22:** ☐done ☐needed
Lipid Panel: ☐done ☐needed	**Thyroid:** ☐done ☐needed	**LFT:** ☐done ☐ needed
UA: ☐done ☐needed	**Drug Level:** ☐done ☐needed	**Drug Level:** ☐done ☐needed
PSA: ☐done ☐needed	**Other:** _____ ☐done ☐needed	**Other:** _____ ☐done ☐needed

Please fax physician notes and current lab results to Nursing Services Fax 303-604-5431.

Restrictions/Special Instructions:

Return In ☐**1 YEAR** ☐**2 YEARS** **for next physical exam.**

PHYSICIAN SIGNATURE _____ ***DATE*** _____

Nurse Case Manager/Medical Coordinator Review:

SIGNATURE: DATE: TIME: