FAMILIES FIRST

ANNUAL PHYSICAL EXAM

Date of Visit : _____

Client's Name: _____

Name of Person with Client: _____

Physician's Name: _____

Allergies: _____

Immunization Dates: Tetanus: _____ MMR: _____ Influenza: _____

Additional Immunizations Needed: _____

Complete Medical Problem List: _____

_____

_____

_____

_____

Current Medication List (including all over-the-counter medications and alternative therapies):
**All medications need to be reviewed annually by a physician.

_____

_____

_____

_____

Labs Including Reason for Test (yearly labs, medication regiment or diagnosis): _____

_____

_____

Other Testing Including Reason for Test: _____

_____

If the client is 40 years old or older please fill out Cancer Screening Form.

Families First
34 E. Main Street, PO Box 939, Wilmington, VT 05363
Phone: (802) 464-9633, Fax: (802) 464-3173, 24hr Emergency Pager: (802) 283-4551
email: familiesfirst@familiesfirstvt.com website: www.familiesfirstvt.com

Height: _____ Weight: _____ BMI: _____

B/P: _____ HR: _____ Resp: _____ SpO2: _____ Temp: _____

Eyes: _____ Vision: R 20/_____ L 20/_____ Corrective Lenses: Yes _____ No _____

Ears: _____ Hearing Test: R _____ L _____ Hearing Aids: Yes _____ No ____

General Appearance	
Skin	
Head	
Mouth/Throat	
Neck	
Chest	
Heart	
Lungs	
Abdomen	
Genitalia	
Rectum	
Back/Spine	
Extremities	
Lymph Nodes	
Cranial Nerves	
Reflexes	
Sensory	
Motor Function	

Recommendations for Client's Health: _____

_____

_____

Physician's Signature: _____ Date: _____

Case Manager's Signature: _____ Date Received: _____

Guardian's Name: _____ Date Notified: _____

Agency Nurse's Signature: _____ Date Received: _____

Families First
34 E. Main Street, PO Box 939, Wilmington, VT 05363
Phone: (802) 464-9633, Fax: (802) 464-3173, 24hr Emergency Pager: (802) 283-4551
email: familiesfirst@familiesfirstvt.com website: www.familiesfirstvt.com

FAMILIES FIRST

ANNUAL PHYSICAL EXAM
Cancer Screenings

Date of Visit: _____

Client's Name: _____

List Date of Last Screening or if Client is Due for Screening This Year

Colonoscopy: (50 - 75 years old) every 10 years _____

For Females: Pap Test (21 - 65 years old) every 3 years with HPV screening starting at age 30_____

For Females: Mammogram (50 - 74 years old) every 2 years_____

For Males: Digital Rectal Exam and/or PSA (40 years and older) per symptoms, family history, and/or risk factors _____

Notes:

_____

_____

_____

Physician's Signature: _____ Date: _____

Case Manager's Signature: _____ Date Received: _____

Guardian's Name: _____ Date Notified: _____

Agency Nurse's Signature: _____ Date Received: _____

Families First
34 E. Main Street, PO Box 939, Wilmington, VT 05363
Phone: (802) 464-9633, Fax: (802) 464-3173, 24hr Emergency Pager: (802) 283-4551
email: familiesfirst@familiesfirstvt.com website: www.familiesfirstvt.com