ANNUAL PHYSICAL EXAM

Date of Visit :_____Client's Name: _____

Name of Person/s with Client: _____

Medical Practitioner'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 and re-prescribed annually.

_____

_____

_____

_____

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

_____

_____

Other Testing, Including Reason for Test: _____

_____

_____

Families First
11 University Way, Brattleboro, VT 05301
Phone: 802-275-4919 Fax: 802-275-4922
Email: nurse@familiesfirstvt.org

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

Form.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: _____

_____

Medical Practitioner's Signature:_____ Date:_____

Service Coordinator's Signature:_____Date Received: ___ Guardian's

Name:_____Date Notified: _____

Agency Nurse's Signature:_____Date Received: ___

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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.

Breast: _____

Cervical: _____

Colorectal: _____

Lung: _____

Prostate: _____

Notes:

_____

_____

_____

Medical Practitioner's Signature:_____Date:_____

Service Coordinator's Signature:_____Date Received: _____

Guardian's Name:_____Date Notified: _____

Agency Nurse's Signature:_____Date Received: _____

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