ANNUAL PHYSICAL FORM

Innovations In Learning requires an annual physical exam and negative TB test for all consumers in Day Service.

Name: ____ **Date of Birth:** ______________________________

Date of Physical: _____________________ **Gender:** _____ **Male** _____**Female**

HEALTH HISTORY and INFORMATION		
Diagnosis	Date of Diagnosis	Treating Physician

Allergies: ____
____
____

Do you require a specialized diet?	Yes	No
Do you currently have a dining/choking risk plan?	Yes	No
Do you have seizures?	Yes	No
Do you have a seizure risk plan?	Yes	No
Do you have a hearing loss?	Yes	No
Do you wear a hearing aid?	Yes	No
Do you have a visual impairment?	Yes	No
Do you wear glasses/contacts?	Yes	No
Do you have any special devices for bowel or bladder function?	Yes	No
Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?	Yes	No
Do you have muscle spasticity?	Yes	No
Do you require any environmental modifications?	Yes	No
Do you require any other medical accommodations?	Yes	No
Have you ever experienced visual or auditory hallucinations/delusions?	Yes	No
Have you ever been diagnosed with a mood related disorder?	Yes	No
Do you smoke? If so, how often? ______________	Yes	No
Do you drink alcohol? If so, how often? _____________	Yes	No

Please provide details for any question answered with a "yes": ____
____
____
____
____

Significant Medical/Surgical History: ____
____
____
____
____

PHYSICAL EXAM		
Height:		Weight:
Blood Pressure:		Heart Rate:
Medical:	**Normal**	**Abnormal Findings**
Appearance		
Eyes/ears/nose/throat		
Hearing		
Pulses		
Lungs		
Abdomen		
Thyroid		
Gastro-intestinal		
Skin		
Neurologic		
Genitourinary (males only)		
Gynecological (females only)		
Musculoskeletal:	**Normal**	**Abnormal Findings**
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional Walk		

Additional Recommendations/Referrals: ____
____
____
____
____

MEDICATIONS			
Medication	**Prescribing Physician**	**Date Initially Prescribed**	**Dosage/Time**

I hereby attest that, to the best of my knowledge, the information provided above is accurate and complete.

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Physician Signature/Date