PROGRESS INC.
ANNUAL MEDICAL EXAMINATION

DATE OF EXAMINATION: ____________________

NAME: ___________________________ SEX: __________ DOB:____________
WEIGHT: ________________ HEIGHT: ________________ TEMPERATURE: ________
PULSE: ____________ BLOOD PRESURE: __________________

<u>NORMAL FINDINGS = "WNL" / RECORD ABNORMALITIES:</u>

HEAD, FACE, NECK AND SCALP: ____
SINUSES: _____________________________ NOSE AND THROAT: _________________
EARS, DRUMS, GENERAL: _________________**FUNCTIONAL HEARING:** __________
EYES, GENERAL: _________________________ **FUNCTIONAL VISION:** ____________
SIZE AND SHAPE OF PUPILS: ____
REACTION TO LIGHT AND ACCOMMODATIONS: _______________________________
LUNGS AND CHEST (Include breasts): _____________________________________
HEART: ______________________________ VASCULAR: __________________________
ABDOMEN AND VISCERA (Including hernia): _______________________________
EXTERNAL GENITALIA: ____
PELVIC ORGANS (FEMALE ONLY): ____
ANUS AND RECTUM: ____
EXTREMITIES, UPPER: ____
EXTREMITIES, LOWER: _________________________________ FEET: ______________
SKIN AND LYMPHATICS, including identifying marks, scars, and tattoos:
____
____
MUSCLES, BONES AND JOINTS: ____
ENDOCRINE SYSTEM: ____
DEEP REFLEXES: ____________________________ TEETH: ________________________
URINE ANALYSIS DATE: ____________ S.G.: _______ ALB.: _______ SUGAR: ________
MICROSCOPIC: ____

DATE AND PLACE OF X-RAY AND REPORT: ____________________________________

RECORD OF IMMUNIZATIONS: (include dates)
TETANUS TOXOID: DATE: _________ POLIO VACCINE: DATE: ____________________
TB TEST: DATE: ______________________ RESULTS: ______________________________

MEDICATIONS (include dosages): ____
____
____
____
____
____

DIAGNOSIS: ____
____
____
____
____
____
____

TREATMENT RECOMMENDATIONS: ____________________________________
____
____
____
____
____
____
____
____

OTHER PERTINENT FINDINGS: suggestions and additional information: _______________
____
____
____
____
____

□ **Repeat physical in one (1) year,** □ **two (2) years,** □ **three (3) years.**

NUTRITIONAL STATUS: Please indicate the type of diet the Patient needs:
__________ Regular
__________ Modified, (Diabetic, bland, soft, mechanical, weight reduction)
__________ Other: ____
____
____

NAME: ____________________________ continues to need Home Community Based Services.

____ ________________
Physician's signature Date

____
____
____
Address