



**DELAWARE HEALTH & SOCIAL SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
COMMUNITY SERVICES**

**Physical Examination**

Name: \_\_\_\_\_ MCI #: \_\_\_\_\_ Sex: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Exam Date: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Temp: \_\_\_\_\_ BP: \_\_\_\_\_

P: \_\_\_\_\_ R: \_\_\_\_\_ Pulse Ox: \_\_\_\_\_

Allergies: \_\_\_\_\_

Physical Examination:	Normal	Abnormal	Comments
Scalp/Hair			
Ears/Hearing			
Eyes/Vision			
Nose/Mouth/Pharynx			
Gum Check (if Edentulous)			
Neck/Thyroid			
Skin/Nails			
Chest/Breast			
Heart			
Lungs			
Spine			
Abdomen			
Genitalia (external)			
Prostate			
Pelvic/Pap Smear			
Upper Extremities			
Lower Extremities			

Colon/rectal Cancer Screening: \_\_\_\_\_ Guaiac Result: \_\_\_\_\_

Last PPD: \_\_\_\_\_ Results: \_\_\_\_\_ If Positive Hx - Active S/S: Yes \_\_\_\_\_ No \_\_\_\_\_

**Immunizations**

Immunization	Date Last Given	Current Y/N	Current Medical Diagnosis	
Td or Tdap			1.	8.
Influenza			2.	9.
Pneumococcal			3.	10.
Zoster			4.	11.
Hepatitis B vaccine			5.	12.
Varicella (Chicken Pox)			6.	13.
Other:			7.	14.

Immunizations given at time of exam: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Diet: \_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_

**Lab Tests and/or Diagnostics Ordered**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>Restrictions:</b>	<b>Unlimited</b>	<b>Limited</b>	<b>Avoid</b>
<b>Walking</b>			
<b>Standing</b>			
<b>Stooping</b>			
<b>Kneeling</b>			
<b>Lifting</b>			
<b>Pushing</b>			
<b>Pulling</b>			
<b>Other</b>			

Next recommended physical exam - Annual \_\_\_\_\_ 2 yrs \_\_\_\_\_ 3 yrs \_\_\_\_\_

Recommendations/Referrals: \_\_\_\_\_  
\_\_\_\_\_

Adaptive Equipment: \_\_\_\_\_  
\_\_\_\_\_

**Medications: [Include dosage and frequency]**


Was the individual informed of his/her physical status? Yes \_\_\_\_\_ No \_\_\_\_\_

If "no" or "unable", was the individual's physical status discussed with his/her surrogate/guardian?

Yes \_\_\_\_\_ No \_\_\_\_\_

Does the individual have the capacity to understand the significant benefits, risks and alternatives to proposed health care and make and communicate decisions? Yes \_\_\_\_\_ No \_\_\_\_\_

Return To: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_