

WINGS -JAYC II, LLC
Office - 320-593-0440; Fax 320-593-0442
Physical Health Examination

Client: _____ Date of physical Exam: _____

Diagnosis code(s) _____; _____; _____

Name of Physician Completing Physical Exam: _____

Doctor's office Phone: _____

Pertinent Findings: Must include a review of systems and statement that the resident is free of communicable disease as well as other information requested here:

Past Illness -check all that apply

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Digestive Disease |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thromobophlebitis | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Childbirth Complications |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Serious Injury | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Use of Alcohol |
| <input type="checkbox"/> Use of cigarettes | <input type="checkbox"/> Use of drugs |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Use of prescription drugs | <input type="checkbox"/> Other (please explain below) |

Explanation:

Date of Last Tetanus: _____

Physical Examination:

Blood Pressure: _____ Temperature _____ Pulse : _____ Respirations _____

Weight: _____ Height: _____ Urinalysis for Drug Screen: _____

WINGS -JAYC II, LLC
Office - 320-593-0440; Fax 320-593-0442
Physical Health Examination

Mantoux:

Date of last Mantoux Test: _____ We prefer Mantoux test or check X-ray be done

Results: Negative Positive (Circle one)

Or date of last chest X-ray: _____

Result of last Chest X-ray: _____

Is this resident free from communicable disease: Yes No (Circle One)

Does this resident have a form of herpes: Yes No (circle one)

Immunizations: Have you been immunized against:

Small Pox	() No () Yes	Last shot _____
Tetanus	() No () Yes	Last shot _____
Polio (shots/oral Vaccine)	() No () Yes	Last shot _____
Measles	() No () Yes	Last shot _____
German Measles	() No () Yes	Last shot _____
Other	() No () Yes	Last shot _____

Prescribed Medication/Treatment Orders: Current medication and treatments are listed. Unless otherwise specified, all medications/treatments are good for one year.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

No Medications _____ (please check if this applies)

WINGS -JAYC II, LLC
Office - 320-593-0440; Fax 320-593-0442
Physical Health Examination

Review of System: Please explain all abnormal findings below:

Normal Finding	Abnormal
1. Skin _____	_____
2. Head _____	_____
3. Eyes _____	_____
Vision _____	_____
4. Ears _____	_____
Hearing _____	_____
5. Nasal Pharyngeal _____	_____
6. Neck, Back, Extremities _____	_____
7. Breast _____	_____
8. Cardiovascular _____	_____
9. Abdomen _____	_____
10. Musculoskeletal _____	_____
11. Repertory _____	_____
12. Neurological _____	_____
13. Glandular _____	_____
14. Genital _____	_____
Pap Smear _____	_____
Gonorrhea Culture _____	_____
15. Urinary Tract _____	_____
16. Anorectal _____	_____
Hemocult _____	_____

Does this resident require follow-up visits with a physician for physical health problems?

Yes No (circle one)

Type of Diet: Regular Special (circle one)

Diagnosis and Impression of Health:

Additional Comments or recommendations:

Your Signature indicated you have informed the client of their conditions

Date: _____ Phone: _____

Address: _____

City _____ State _____ ZIP _____

Physicians Signature: _____

MANTOUX TEST VERIFICATION

Patient Name: _____ Date _____

Patient states he/she has had previous mantoux

Yes _____ No _____ Unsure _____

If yes, Has it been Positive _____ Negative _____

If positive: Dr. _____ Notified date: _____ Time: _____

Mantoux held _____ Nurse Signature: _____

Mantoux was given on _____ Time: _____ a.m. p.m.

In right forearm _____ Left forearm _____

Nurse Signature: _____

Results after _____ hours Negative Positive

Nurse Signature

FREE OF COMMUNICABLE DISEASE STATEMENT

Date: _____

To the best of my knowledge, the above stated patient is apparently free of communicable diseases.

Doctor Signature: _____