SPECTRUM COMMUNITY SERVICES

ANNUAL PHYSICAL EXAMINATION

NAME: _____ DOB:_____ ID#: MEDICAID _____

MEDICARE _____

Date of Examination: _____ Physician: _____

Diagnosis: _____

Allergies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

GENERAL APPEARANCE	WITHIN NORMAL LIMITS	CONCERNS
HEAD		
EYES		
EARS		
NOSE		
ORAL CAVITY		
NECK		
LUNGS		
CARDIOVASCULAR		
ABDOMEN		
GENITALIA		
SKIN		
MUSCULAR-SKELETAL (Strength, tone, bulk, posture, gait, etc.)		

ANNUAL PHYSICAL EXAMINATION - Side 2

MEDICATION	DOSAGE	TREATMENT FOR

Does this person have any communicable diseases? YES / NO

RECOMMENDATIONS/COMMENTS: (Please include recommended diet or weight concerns)

I have examined this person and find him / her able to participate in the program (employment or recreational) other than those limitations shown.

PHYSICIANS SIGNATURE

PHYSICIANS NAME (PLEASE PRINT)

PHYSICIANS ADDRESS

DATE