AbilityPoint
Medical Examination

PATIENT'S NAME_____ SOCIAL SECURITY # _____

SEX: MALE____ FEMALE____ BIRTH DATE: _____

HAS PATIENT EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK)

_____ Frequent Headaches
_____ Difficulty with Vision
_____ Difficulty with Hearing
_____ Convulsions or Seizures
Freq. _____
_____ Unusual Irritability
_____ Difficulty with Memory
_____ Choking on Food/Fluid
_____ Fainting
_____ Unusual Weight Gain or Loss
_____ Diarrhea or Constipation
_____ Loss of Appetite
_____ Hemorrhoids
_____ Frequent Indigestion
_____ Hernia or "Ruptures"
_____ Varicose Veins or Leg Ulcers
_____ Fever or Night Sweats
_____ Cough Producing Blood
_____ Persistent Coughing
_____ Tuberculosis
_____ Excessive Fatigue
_____ Pain in Chest
_____ Shortness of Breath
_____ Asthma or Hay Fever
_____ Swollen Ankles
_____ Arthritis/Swollen Joints

_____ Persistent or Recurring Skin Rashes or Lesions
_____ Burning upon Urination
_____ Blood in Urine
_____ Nervous Breakdown
_____ Heart Attack
_____ Stroke
_____ Sexually Transmitted Diseases
_____ Diabetes
_____ Hypoglycemia
_____ Hepatitis
_____ Bed Wetting
_____ PMS
_____ Fractures (Describe/Dates)_____
_____
_____ Operations (Describe/Dates) _____
_____
_____ Other Hospitalizations (Describe/Dates) ____
_____
_____ Serious Injuries (Describe/Dates) _____
_____
_____ Food Allergies (Specify) _____
_____
_____ Drug Allergies (Specify) _____
_____

LAB/IMMUNIZATION RECORD (GIVE LAST DATE ON THE LINE TO THE RIGHT AND ATTACH LAB WORK WHEN POSSIBLE):

T.B. Test _____
Negative _____ Positive _____
Chest X-Ray (Necessary only for Positive TB or those unable to take TB Test)
Negative _____ Positive _____
Hepatitis B _____
Negative _____ Positive _____
DPT/DT _____
U/A _____

Blood Work _____
CBC _____ SMAC _____ VDRL _____
Tetanus _____
Mumps _____
Measles _____
Rubella _____
Polio _____
Other _____
_____
_____

Is Patient now under your care or any other Physician? _____ Yes _____ No
If yes, give nature of condition and plan for treatment: _____
_____

PHYSICAL EXAMINATION (DEVIATIONS FROM NORM SHOULD BE DESCRIBED):

Height _____Ft. _____In. Weight: _____Lbs. Temperature: _____F
Blood Pressure: _____ Pulse: _____

Vision: Right _____ Left _____
Other Findings: _____
Hearing: Right _____ Left _____
Other Findings _____
Nose: _____
Throat: _____
Mouth: _____
Neck: _____
Lymphatic Systems: _____
Breasts: _____
Lungs: Right _____ Left _____
Cardiovascular System: _____
Abdomen: _____
Hernia: _____
Genito-Urinary: _____
Ano-Rectal: _____
Nervous System: _____
Skin: _____
Varicose Veins: _____

DIAGNOSIS	ICD-9 CODE
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Do you have knowledge of substance abuse by this individual? _____Yes _____No

PROGNOSIS: _____
Is the patient's condition expected to exhibit deterioration or improvement?
_____Yes _____No If Yes, In what way? _____
_____
Activities to be avoided: _____
Weight restrictions: _____
Adaptive Devices: What devices are used and when are they needed? _____
_____

PLEASE LIST ALL MEDICATIONS, NON-PRESCRIPTION AND PRESCRIPTION, CURRENTLY BEING TAKEN BY THIS INDIVIDUAL:

Medication	Prescribing Dr.	Purpose	Dosage	Frequency

RECOMMENDATIONS/COMMENTS: _____
_____
_____

SIGNED: _____ DATE: _____
LICENSED PHYSICIAN

PHYSICIAN'S PRINTED NAME: _____
PHYSICIAN'S ADDRESS & PHONE NUMBER: _____
PHYSICIAN'S MEDICAID PROVIDER NUMBER: _____