



Patient Identification

Patient Name:				Date of Exam:	
Physician's Name:			UCI#	SS#	
Sex:	DOB:	Age:	Height:	Weight:	
GENERAL HEALTH	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
AUDITORY IMPAIRMENT	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Explain:</i>		
VISUAL IMPAIRMENT	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Explain:</i>		
ALCOHOLIC PROBLEMS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Explain:</i>		
SPECIAL DIET	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Specify:</i>		
MEDICATIONS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>Specify:</i>		
TUBERCULOSIS EXAMINATION	<input type="checkbox"/> Active	<input type="checkbox"/> Inactive or None		<i>Date of Exam:</i>	
OTHER CONTAGIOUS OR INFECTIOUS DISEASES	<input type="checkbox"/> None	<input type="checkbox"/> Yes	<i>Explain:</i>		
HEAD (eyes, ears, nose, throat)					
HEART (arrhythmia)					
LUNGS (breath sounds)					
CHEST (breasts)					
ABDOMEN (kidneys, spleen, liver)					
ADENOPATHY (neck, axilla, groin)					
GENITALIA (pelvic)					
RECTAL					
MUSCULO SKELETAL					
NERVOUS SYSTEM					

<p>SUMMARY OF FINDINGS (For residents, include diagnosis. For service providers, describe limitations on physical abilities.):</p>

Physician Name (please print)

Physician's Signature

Date

For Clients in Residential Placement Only

Check one

	YES	NO	COMMENTS
Bathes self			
Dresses self			
Feeds self			
Cares for own toilet needs			
Is able to care for all personal needs			
Can administer own medication			
Needs help with medication			
Medication prescribed and instructions given to patient (please specify)			

IMPORTANT: AMBULATORY NON-AMBULATORY*

***NON-AMBULATORY** means that the individual is unable to leave a building unassisted under emergency conditions. It includes any person unable, or likely unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshall, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walker, and wheelchairs. If NON-AMBULATORY is marked, facility must have a "non-ambulatory" clearance on the license.

Physician Name (please print)

Address

Telephone Number

Physician Signature

Date