Annual Physical Form

Name: _____ DOB: _____ Date: _____
Diagnosis: _____
Allergies: _____

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____
Temperature: _____ Pulse: _____ Respiration: _____
Results of Physical Examination: _____
_____
_____

Current Test Results / Status

PPD: _____ Urinalysis: _____
Results *Date* *Results* *Date*
HGB: _____ TD Booster: _____
Results *Date* *Results* *Date*
HB Screening: _____ HB Vaccine: _____
Results *Date* *Results* *Date*
Other: _____
Name of Test *Date* *Results*

Other Important Information

Operations: _____
Serious Injuries: _____
Chronic or Reoccurring Illnesses: _____

Current Medication(s) or None

Type	Dosage/Frequency	Purpose	Side Effects

Diet/Nutritional Requirements:
_____
_____
_____

Person Centered Care Services
150 Granite Ave.
Staten Island, NY 10303
718-370-1088

Restrictions While in Program

This individual is NOT to participate in these activities checked below:

☐ Swimming ☐ Use of stairs ☐ Strenuous Activities ☐ Other: _____

Check all that apply:

☐ Obesity ☐ COPD/ Asthma ☐ PVD Claudication ☐ Hypertension

☐ Diabetes ☐ CHF/Myopathy ☐ Arrhythmia ☐ Hypotension

☐ Syncope ☐ CVD/CAD ☐ Seizures ☐ Other: _____

Additional Information:

_____

_____

_____

_____ _____

Physician Signature Date

_____ _____

Address Telephone Number/Fax

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