ARIEL
Clinical Services
Children • Families • Adults

Annual Health Evaluation

Patient Name: Date of Birth:

Patient Address:

Physician's Name: Date of Exam:

1. General Information: Sex: Weight: Height:

Blood Pressure: Pulse:

Allergies/Medications:

2. Ears: Nose:

Throat:

3. Eyes/Vision:

Current Exam Requested:

4. Cardiopulmonary Status:

5. Abdomen:

Specific Diet Currently Prescribed:

6. Genitalia:

7. Muscular/Skeletal:

8. Neurological: _____

_____

9. Medications Currently Prescribed: _____

_____

10. Impressions/Diagnosis: _____

_____

_____

Lab Work/Diagnostic Tests/Consult Request: _____

_____

_____

Additional Medication/Treatment Prescribed: _____

_____

11. Is the patient free of communicable diseases on this date? _____

Recommendation: _____

12. May the patient participate in Special Olympics? _____

Restrictions: _____

13. Is staff supervision of medication requested? _____

14. Vaccinations Given (please list dates given): _____

TB Test: _____ TB Result: _____ Flu Shot: _____

Hep B: _____ Pneumovax: _____

MMR: _____ Rubella: _____

Tetanus/Diphtheria: _____ Other: _____

Physician Signature: _____

Date: _____