Annual Health Evaluation

Box must be filled out completely by person attending with member.

Member Name: _____ **Date of Exam:** _____

Physician Name: _____ **Time of Appt:** _____

Physician Address: _____

Height: _____ **Weight:** _____**Pulse:** _____ **Blood Pressure:** _____**Allergies:** _____

Part of body: For the part of body that you are evaluating, select a condition and write a detailed comment.	**Within normal limits**	**Condition needs further evaluation**	**Condition Referred to Specialist**
Ears /Nose/Throat			
Eyes/ Vision			
Cardiopulmonary Status			
Abdomen/Genitalia			
Muscular/Skeletal			
Neurological			

Medications/ Treatments Currently Prescribed: (attach if needed)

_____

Is staff supervision of medication required? Y/N Comments: _____

Special Diet Prescribed: _____

Impressions/Diagnosis: _____

Lab Work/Diagnostic Tests/ Consult Request: _____

Is the patient free of communicable diseases on this date? Yes No
If no, what are your recommendation? _____

May the patient participate in the Special Olympics? Yes No
If yes, are there restrictions? _____

Medical Provider Signature: _____ **Date:** _____