ANNUAL PHYSICAL EXAMINATION FORM

Part One: TO BE COMPLETED PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

Sex: ☐Male ☐Female Name of Accompanying Staff: _____

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS *(Attach Lifetime Medical History Summary and Chronic Health Problems List)*

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years):* _____/_____/_____

Hepatitis B: _____/_____/_____ _____/_____/_____ _____/_____/_____

Flu Shot: _____/_____/_____ **Pneumovax:** _____/_____/_____

Other *(specify)* _____

Tuberculosis (TB) SCREENING: *(every 2 years by Mantoux method, if positive- initial chest x-ray should be done)*

Date given _____ Date read _____ Results _____

Chest x-ray (date) _____ Results _____

Other *(specify)* _____ **Date:** _____ **Results:** _____

_____

_____ _____ _____

Name of physician *(please print)* **Physician's Signature** **Date**

Physician Address: _____ **Physician Phone Number:** _____