WINGS -JAYC II, LLC
Office - 320-593-0440; Fax 320-593-0442
Physical Health Examination

Client: _____ Date of physical Exam: _____

Diagnosis code(s) _____; _____; _____

Name of Physician Completing Physical Exam: _____

Doctor's office Phone: _____

Pertinent Findings: Must include a review of systems and statement that the resident is free of communicable disease as well as other information requested here:

Past Illness -check all that apply

_____ Allergies
_____ Heart Attack
_____CVA
_____ Thromobophlebitis
_____ Thyroid Disease
_____Liver Disease
_____Serious Injury
_____ Surgery
_____ Use of cigarettes
_____ Skin
_____ Use of prescription drugs
_____ Kidney Disease
_____ Digestive Disease
_____ Cancer
_____ Bladder Infection
_____Childbirth Complications
_____Arthritis
_____ Fractures
_____ Use of Alcohol
_____ Use of drugs
_____ Venereal Disease
_____ Other (please explain below)

Explanation:

_____

_____

_____

Date of Last Tetanus: _____

Physical Examination:

Blood Pressure: _____ Temperature _____ Pulse : _____Respirations_____

Weight: _____ Height:_____ Urinalysis for Drug Screen: _____

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Mantoux:

Date of last Mantoux Test: _____ We prefer Mantoux test or check X-ray be done

Results: Negative Positive (Circle one)

Or date of last chest X-ray: _____

Result of last Chest X-ray: _____

Is this resident free from communicable disease: Yes No (Circle One)

Does this resident have a form of herpes: Yes No (circle one)

Immunizations: Have you been immunized against:

Small Pox	( ) No	( ) Yes	Last shot_____
Tetanus	( ) No	( ) Yes	Last shot_____
Polio (shots/oral Vaccine)	( ) No	( ) Yes	Last shot_____
Measles	( ) No	( ) Yes	Last shot_____
German Measles	( ) No	( ) Yes	Last shot_____
Other	( ) No	( ) Yes	Last shot_____

_____

Prescribed Medication/Treatment Orders: Current medication and treatments are listed. Unless otherwise specified, all medications/treatments are good for one year.

1.
2.
3.
4.
5.
6.

No Medications _____ (please check if this applies)

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Review of System: Please explain all abnormal findings below:

	Normal Finding	Abnormal
1. Skin	_____	_____
2. Head	_____	_____
3. Eyes	_____	_____
Vision	_____	_____
4. Ears	_____	_____
Hearing	_____	_____
5. Nasal Pharyngeal	_____	_____
6. Neck, Back, Extremities	_____	_____
7. Breast	_____	_____
8. Cardiovascular	_____	_____
9. Abdomen	_____	_____
10. Musculoskeletal	_____	_____
11. Repertory	_____	_____
12. Neurological	_____	_____
13. Glandular	_____	_____
14. Genital	_____	_____
Pap Smear	_____	_____
Gonorrhea Culture	_____	_____
15. Urinary Tract	_____	_____
16. Anorectal	_____	_____
Hemocult	_____	_____

Does this resident require follow-up visits with a physician for physical health problems?
Yes No (circle one)

Type of Diet: Regular Special (circle one)

Diagnosis and Impression of Health:
_____

_____

Additional Comments or recommendations:
_____

_____

Your Signature indicated you have informed the client of their conditions

Date:_____ Phone: _____

Address: _____

City _____State _____ZIP_____

Physicians Signature: _____

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MANTOUX TEST VERIFICATION

Patient Name: _____ Date _____

Patient states he/she has had previous mantoux

Yes _____ No ____ Unsure _____

If yes, Has it been Positive _____ Negative _____

If positive: Dr. _____ Notified date: _____ Time: _____

Mantoux held _____ Nurse Signature:_____

Mantoux was given on _____ Time: _____ a.m. p.m.

In right forearm _____ Left forearm _____

Nurse Signature: _____

Results after _____hours Negative Positive

Nurse Signature

FREE OF COMMUNICABLE DISEASE STATEMENT

Date: _____

To the best of my knowledge, the above stated patient is apparently free of communicable diseases.

Doctor Signature: _____