

The Arc of Sedgwick County
Medical Examination

PATIENT'S NAME _____ SOCIAL SECURITY # _____

SEX: MALE _____ FEMALE _____ BIRTH DATE: _____

HAS PATIENT EXPERIENCED ANY OF THE FOLLOWING? (PLEASE CHECK)

- | | |
|---|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Persistent or Recurring Skin Rashes or Lesions |
| <input type="checkbox"/> Difficulty with Vision | <input type="checkbox"/> Burning upon Urination |
| <input type="checkbox"/> Difficulty with Hearing | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Convulsions or Seizures | <input type="checkbox"/> Nervous Breakdown |
| Freq. _____ | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Unusual Irritability | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Difficulty with Memory | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Choking on Food/Fluid | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Unusual Weight Gain or Loss | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diarrhea or Constipation | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Fractures (Describe/Dates) _____ |
| <input type="checkbox"/> Frequent Indigestion | _____ |
| <input type="checkbox"/> Hernia or "Ruptures" | <input type="checkbox"/> Operations (Describe/Dates) _____ |
| <input type="checkbox"/> Varicose Veins or Leg Ulcers | _____ |
| <input type="checkbox"/> Fever or Night Sweats | <input type="checkbox"/> Other Hospitalizations (Describe/Dates) _____ |
| <input type="checkbox"/> Cough Producing Blood | _____ |
| <input type="checkbox"/> Persistent Coughing | <input type="checkbox"/> Serious Injuries (Describe/Dates) _____ |
| <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Food Allergies (Specify) _____ |
| <input type="checkbox"/> Pain in Chest | _____ |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Drug Allergies (Specify) _____ |
| <input type="checkbox"/> Asthma or Hay Fever | _____ |
| <input type="checkbox"/> Swollen Ankles | _____ |
| <input type="checkbox"/> Arthritis/Swollen Joints | _____ |

LAB/IMMUNIZATION RECORD (GIVE LAST DATE ON THE LINE TO THE RIGHT AND ATTACH LAB WORK WHEN POSSIBLE):

T.B. Test _____	Blood Work _____
Negative _____ Positive _____	CBC _____ SMAC _____ VDRL _____
Chest X-Ray (Necessary only for Positive TB or those unable to take TB Test)	Tetanus _____
Negative _____ Positive _____	Mumps _____
Hepatitis B _____	Measles _____
Negative _____ Positive _____	Rubella _____
DPT/DT _____	Polio _____
U/A _____	Other _____

Is Patient now under your care or any other Physician? _____ Yes _____ No
If yes, give nature of condition and plan for treatment: _____

PHYSICAL EXAMINATION (DEVIATIONS FROM NORM SHOULD BE DESCRIBED):

Height _____ Ft. _____ In. Weight: _____ Lbs. Temperature: _____ F
Blood Pressure: _____ Pulse: _____

Vision: Right _____ Left _____
 Other Findings: _____
 Hearing: Right _____ Left _____
 Other Findings _____
 Nose: _____
 Throat: _____
 Mouth: _____
 Neck: _____
 Lymphatic Systems: _____
 Breasts: _____
 Lungs: Right _____ Left _____
 Cardiovascular System: _____
 Abdomen: _____
 Hernia: _____
 Genito-Urinary: _____
 Ano-Rectal: _____
 Nervous System: _____
 Skin: _____
 Varicose Veins: _____

DIAGNOSIS

ICD-9 CODE

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have knowledge of substance abuse by this individual? _____ Yes _____ No

PROGNOSIS: _____

Is the patient's condition expected to exhibit deterioration or improvement?

_____ Yes _____ No If Yes, In what way? _____

Activities to be avoided: _____

Weight restrictions: _____

Adaptive Devices: What devices are used and when are they needed? _____

PLEASE LIST ALL MEDICATIONS, NON-PRESCRIPTION AND PRESCRIPTION, CURRENTLY BEING TAKEN BY THIS INDIVIDUAL:

Medication	Prescribing Dr.	Purpose	Dosage	Frequency

RECOMMENDATIONS/COMMENTS: _____

SIGNED: _____
 LICENSED PHYSICIAN

DATE: _____

PHYSICIAN'S PRINTED NAME: _____
 PHYSICIAN'S ADDRESS & PHONE NUMBER: _____
 PHYSICIAN'S MEDICAID PROVIDER NUMBER: _____