Lackawanna College Allied Health Division Medical Form

ANNUAL PHYSICAL EXAMINATION FORM

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

________________________________________

CURRENT MEDICATIONS (Attach a second page if needed):

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Diagnosis</th>
<th>Prescribing Physician Specialty</th>
<th>Date Medication Prescribed</th>
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Allergies/Sensitivities: __________________________________________________________

Contraindicated Medication: ______________________________________________________

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: Pulse: _____ Respirations: ____ Temp: ____ Height: Weight:

EVALUATION OF SYSTEMS

Eyes: ________________________________________________________________

Ears: ________________________________________________________________

Nose Mouth/Throat: ______________________________________________________

Head/Face/Neck: _________________________________________________________

Lungs: ________________________________________________________________

Cardiovascular: _________________________________________________________

Extremities: ____________________________________________________________

Abdomen: ______________________________________________________________

Gastrointestinal: _______________________________________________________

Endocrine: _____________________________________________________________
Musculoskeletal: ___________________________________________________________
Integumentary: __________________________________________________________
Renal/Urinary: ___________________________________________________________
Lymphatic: _____________________________________________________________
Nervous System: _________________________________________________________

VISION SCREENING Is further evaluation recommended by specialist? Yes No

HEARING SCREENING Is further evaluation recommended by specialist? Yes No

Part Three: Additional Information

Lifetime medical history summary reviewed?
Medication added, changed, or deleted (from this appointment): ________________________
Special medication considerations or side effects: ______________________________________
Free of communicable diseases? Yes No (if no, list specific precautions to prevent the spread
of disease to others): _________________________________________________________
Limitations or restrictions for activities (including work day, lifting, standing, and
bending) No Yes (specify): ____________________________________________ Change in
health status from previous year? No Yes (specify): __________________ Specialty
consults recommended? No Yes (specify) ___________________________ Seizure
Disorder present? No Yes (specify type): __________________
Date of Last Seizure_____

Any Additional Comments:
__________________________________________________________________________
____________________________________________________________________________

Name of physician (please print) ____________________________ Physician’s
Signature: ______________________ Date: ______________________