4601 N CHOCTAW RD, CHOCTAW, OK 73020 • 405.390.4400

PHYSICAL EXAMINATION

Participant Name: ____ Date: _________________

DOB: ________________ SSN: ___________________________

Ht: ____ft. ____ in. Wt. ______lbs. BP ________ P_____ Resp.________

Allergies: Medication: _____________________ Food: _______________________

MEDICAL DIAGNOSIS:

1. _________________ 2. ___________________ 3. ___________________

4. __________________ 5.____________________ 6. ___________________

TEETH: Own Teeth ______ Dentures: Y / N Upper __ Lower __

VISION: good ___ fair___ poor ___ Glasses: Y / N

HEARING: good ____ fair ____ poor ____ Hearing Aide: Y / N Right ___ Left ___

LUNGS: ______________________________ **HEART**: _______________________________

GI: _____________ Constipation ___________ Diarrhea _______ Incontinence ______

URINARY: ___________________ Chronic UTI ________________ Incontinence ______

EXTREMITIES: __________________Edema ________________Skin Condition: __________

MENTAL STATUS:

Memory Loss: Y / N Short term: ____________ Long term: ____________

Dementia: Y / N Type ________________________ Stage _________________

Depression: Y / N Anxiety _____________________ Other _________________

Physician's Signature: _________________________________ Date: ________________

Participant's Name:______________________________

CURRENT MEDICATIONS **Dosage** **Frequency**

____

____

____

____

Standing Orders:
_____ Tums, Antacid, Calcium Carbonate, 750 mg, 2 tabs PRN, for indigestion
_____ Tylenol 325 / 500 mg 1 or 2 tabs q 4-6 hrs PRN pain or elevated temp
_____ Imodium AD 1 caplet after each loose stool x2 PRN diarrhea
_____ OTC throat lozenges 1 for sore throat or cough PRN every hour x 3

Date of last Influenza injection: _________

DIET: General/Regular: _____________ Mechanical soft:_______ Pureed:_______

General/Regular with Limited Concentrated Sweets: _______________

General/Regular with No Added Salt: ___________

Chewing difficulties: Y / N Swallowing difficulties: Y / N

ACTIVITY LEVEL: Full _____ Limited _____ Explain ________ _______________

Assistive Devices: _____Cane _____Walker _____Wheelchair _____Braces

Fall Risk: Y / N

Physician's Signature: ___________________________________ Date: _______________

Print name: ____

Address: ____

Telephone ____________________________ Fax _______________________________________