Annual Medical Report

Date of Medical Examination: _____

Name: _____

Address: _____
(Street) (City) (Zip Code)

Date of Birth: _____ Sex: ☐ Male ☐ Female

Diagnosis: _____

General Physical Description: _____

Known Allergies: _____

Please fill information in for all areas that apply:

Temperature_____ Height_____ Weight_____ Blood Pressure_____ Pulse_____

Respiration_____ Cholesterol_____ Eyes_____ Nose_____ Throat_____

Ears_____ Chest_____ Lungs_____ Heart_____

Male Screenings: Prostate-Specific Antigen: _____ Genital Development/Exam_____
(Please list dates) Exam: _____

Female Screenings: Pap Smear:_____ Breast Exam: _____ Mammography:_____
(Please list dates)
Genital Development/Exam_____

Other Screenings/Tests: (Please list dates)

Vision: _____ Urinalysis: _____ Colonoscopy: _____

Hearing: _____ Sigmoidoscopy: _____ Extremities:_____

Dental: _____ Stool Occult Blood: _____ Abdomen: _____

Hernia:_____ Spine:_____

AtlantoAxial Instability Findings (Down Syndrome):_____

EXAM FOR CANCER: Type: _____ Positive Neurological Findings:_____

Last: _____

Type and Frequency of seizures:_____

Immunizations:

Tetanus-Diphtheria: _____

Pneumococcal: _____

Influenza: _____

Measles: _____

Hepatitis Testing Results: _____

Hepatitis B Immunization Series: Initial: _____
30 days: _____
6 months: _____

TB Skin Test Results: _____

Current Medications and Reasons:

_____

_____

_____

_____

Other Risk Factors (Check all that apply)

	Yes	No
High Blood Pressure	☐	☐
High LDL cholesterol	☐	☐
Low HDL cholesterol	☐	☐
High Triglycerides	☐	☐
High Blood Glucose	☐	☐
Family History of:		
Premature Heart Disease	☐	☐
Physical Inactivity	☐	☐
Cigarette Smoking	☐	☐

Recommendations:

Further diagnostic Work (Serology, X-Ray, Etc.):

_____

_____

Treatment (including Immunizations):

_____

_____

Other Recommendations:

_____

_____

Communicable Disease: I certify that no communicable disease is evident at the time of this examination.

Date: _____

_____
Physician Signature

_____
Please Print Physician's Name