CDDO of Butler County
Physical Exam Report

Date of Examination:_____ Physician's Name:_____

Patient's Name:_____ SS#:_____

SEX: ☐ Female ☐ Male Birthdate:_____

PHYSICAL EXAMINATION (DEVIATIONS FROM NORM SHOULD BE DESCRIBED):

Height: _____Ft. _____In. Weight: _____ lbs. Temperature: _____ F

Blood Pressure: _____ Pulse:_____ Vision: Left_____ Right_____

Hearing: Left_____ Right_____

Other findings:

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

☐ Frequent headaches ☐ Difficulty with vision ☐ Difficulty with hearing
☐ Unusual irritability ☐ Difficulty with memory ☐ Convulsions or seizures
☐ Choking on food/fluid ☐ Unusual weight gain/loss Frequency:
☐ Fainting ☐ Diarrhea or constipation ☐ Loss of appetite
☐ Hemorrhoids ☐ Frequent indigestion ☐ Hernia or ruptures
☐ Persistent coughing ☐ Tuberculosis ☐ Varicose veins or leg ulcers
☐ Fever or night sweats ☐ Cough producing blood ☐ Excessive fatigue
☐ Pain in chest ☐ Shortness of breath ☐ Asthma or hay fever
☐ Swollen ankles ☐ Arthritis/swollen joints ☐ Persistent or recurring skin rashes or lesions
☐ Burning during urination ☐ Blood in urine ☐ Stroke
☐ Nervous breakdown ☐ Heart attack ☐ Sexually transmitted diseases
☐ Diabetes ☐ Hypoglycemia ☐ PM
☐ Hepatitis ☐ Bed wetting
☐ Fractures (describe/dates):

☐ Operations (describe/dates):
☐ Other hospitalizations (describe/dates):
☐ Serious injuries (describe/dates):

☐ Food allergies (specify):
☐ Drug allergies (specify):

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

Tetanus:_____ Mumps:
TB Test:_____ ☐ Negative ☐ Positive Measles:
Chest X-Ray (necessary only for positive TB or those unable to Rubella:
take TB test) ☐ Negative ☐ Positive Polio:
Hepatitis B:_____ ☐ Negative ☐ Positive Chicken Pox:
DPT/DT:_____ Other:
U/A:_____

Is patient now under your care or any other physician? ☐ Yes ☐ No
If yes, give nature of condition and plan for treatment:

Nose:_____ Throat:_____ Ano-Rectal:

Mouth:_____
Breasts:_____
Hernia:_____
Nervous System:_____
Lungs: Left_____
Right_____
Lymphatic system:_____
Feet:_____

Neck:_____
Abdomen:_____
Genito Urinary:_____
Cardiovascular System:_____
PMI_____
Rhythm_____
Murmurs_____

Hands:
Orthopedic:
Cervical,spine
Shoulders
Hip
Knee
Ankle
Arm/elbow/wrist:

DIAGNOSIS:

_____
_____
_____

LIMITATIONS/RESTRICTIONS/DIET SPECIFIC INSTRUCTIONS/MAINTENANCE:

Do you have any 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?
_____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 PHYSICIAN	PURPOSE	DOSAGE	FREQ.

RECOMMENDATIONS/COMMENTS:_____

_____

_____

_____ _____

Physician's Signature **Date**

Physician's Printed Name :_____ **Phone :**_____

Physician's Address :_____