EVERGREEN
SERVICE PROVIDERS

ANNUAL PHYSICAL EXAM

Date:______________________________

NAME: ____ AGE:________________

DOCTOR (PLEASE PRINT): ____

DIAGNOSIS: ____

(To be filled in by doctor)

Check each item. Enter "NE" if not evaluated. If abnormal please describe in detail

	Normal	Abnormal	Description
Head, Face, Neck, Scalp			
Nose			
Sinuses			
Mouth and Throat			
Ears (General)			
Eyes (General			
Lungs and Chest			
Heart			
Vascular System			
Abdomen and Viscera			
Anus and Rectum			
Endocrine System			
GU System			
Upper Extremities			
Lower Extremities			
Spine			
Skin			
Neurologic			
Psychiatric			
Pelvic (Female)			

Page 2 for ______________________________ Date ________________

Height: ____________________ Weight: _________________

Temperature ________________ Blood Pressure ____________

Diet: ____

Vision: Right Eye _______________ Left Eye ______________

☐ Recommending formal eye exam ☐ Not recommending formal eye exam

Hearing Right Ear _______________ Left Ear _______________

☐ Recommending formal hearing exam ☐ Not recommending formal hearing exam

Is physical, occupational or speech therapy needed? __________

If yes, was referral made and when? ____

Is a dietary consult indicated? ?________

If yes, is there an order and/or with whom? _______________________________________

Vaccinations Given: ____

Hepatitis B Status: ____

Current Medications: ____

____

____

Recommendations and/or follow up: ____

____

____

____

____

____

Doctor's Signature: _______________________________________ Date: ___________

Doctor's Address: ____

Doctor's Phone Number: ____________________________