DELAWARE HEALTH AND SOCIAL SERVICES
Division of Developmental Disabilities Services

Physical Examination

Name: _____ MCI #: _____ Sex: _____ D.O.B.: _____

Exam Date: _____ Ht: _____ Wt: _____ Temp: _____ BP: _____

P: _____ R: _____ Pulse Ox: _____

Allergies: _____

Was the individual informed of his/her physical status? ☐Yes ☐No
Was the individual's physical status discussed with his/her guardian? ☐Yes ☐No

Return To: _____ Signature: _____

Address: _____ Address: _____

Telephone: _____

Physical Examination:	Normal	Abnormal	Comments
Scalp/Hair	☐	☐	
Ears/Hearing	☐	☐	
Eyes/Vision	☐	☐	
Nose/Mouth/Pharynx	☐	☐	
Gum Check/Oral Health	☐	☐	
Neck/Thyroid	☐	☐	
Skin/Nails	☐	☐	
Chest/Breast	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Spine	☐	☐	
Abdomen	☐	☐	
Genitalia (external)	☐	☐	
Prostate	☐	☐	
Pelvic/Pap Smear	☐	☐	
Upper Extremities	☐	☐	
Lower Extremities	☐	☐	

Colon/rectal Cancer Screening: _____ **Guaiac Result**: _____

Last PPD: _____ Results: _____ If Positive Hx - Active S/S: ☐Yes ☐No

Form: NS FRM 206 Approved: 3/26/18
Ammeded: 5/24/2018, 9/18/2020

Immunizations

Immunization	Date Last Given	Current Y/N	Current Medical Diagnosis
Td or Tdap			
Influenza			
Pneumococcal (PPSV23)			
Zoster			
Hepatitis B vaccine			
Varicella (Chicken Pox)			
Measles, Mumps, Rubella			
Human Papillomavirus			
Other:			
Other:			
Other:			

Immunizations given at time of exam: _____

History of alcohol use, smoking or substance abuse? Please specify: _____

Sexually Active? ☐ Yes ☐ No Planned Parenthood recommended? ☐ Yes ☐ No

Diet: _____

Risk factors for Obesity identified? _____

Mental and Behavioral Health: Does the person exhibit any signs/symptoms of Depression or Dementia that require further attention? ☐ Yes ☐ No
If yes, what appropriate intervention has been employed? _____

Does the person exhibit any signs of Abuse or Neglect including sexual abuse? ☐ Yes ☐ No

If yes, have all appropriate interventions been employed? _____

Other: _____

Lab Tests, Screenings and/or Diagnostics Ordered(PSA, Mammagram, PAP Smear, Lipids, HgA1c, LFT, Hepatitis and other Infectious disease Screening, Cardiovascular screening, Dexa Scan, STD screening, Thyroid function, Echocardiogram, etc.)

Are any recommended screening refused by individual/Guardian/surrogate Decision maker? Please document all refused screenings here: _____

Restrictions:	Unlimited	Limited	Avoid
Walking			
Standing			
Stooping			
Kneeling			
Lifting			
Pushing			
Pulling			
Other			

Next recommended physical exam: ☐ Annual ☐ 2 yrs ☐ 3 yrs

Recommendations/Referrals/Screenings: _____

Adaptive Equipment: _____

Medications: [Include dosage and frequency]

Add Medication