Department of Health and Human Services

Division of Developmental Disabilities

DHHS-DD PHYSICAL EXAMINATION REPORT

NEBRASKA
Good Life. Great Mission.

Name:	**Date of Birth:**
Allergies:	
Medications:	
Date of exam:	**Physician:**
Address:	**Phone:**
Insurance numbers	

PHYSICIAN'S REPORT

Pulse:	Respiration:	B/P:	Height:	Weight:

EXAM	NORMAL		ABNORMAL-Comments/Test Results
Head			
Eyes			
Ears			
Extremities			
Mouth & Throat			
Neck			
Chest			
Heart			
Lungs			
Abdomen			
Pelvic			
Rectal			
Ability to hear			
Ability to see			

Laboratory:

HGB:	HCT:	WBC:	Pap:	Cholesterol:	Other:

UA: S/A, Micro:	Prostate exam completed: ☐ *Yes* ☐ *No*

Mammogram ordered: ☐ *Yes*	Date:_____	*No* ☐ _____

Psychoactive/Anticonvulsant Drug Level:_____

Date of most recent tetanus shot:_____

Immunizations given this visit: _____

Are nutritional needs adequately met? _____ ☐ _____*Yes* _____ ☐ _____*No*
(comment and include specific diet recommendations & target weight)

Medication changes:

Diagnosis if prescribing psychoactive medications:

Other diagnoses:

May use Non-prescription medications according to directions? _____ ☐ _____*Yes* _____ ☐ _____*No*
Limitations:

Recommendations:

Should not participate in:
☐ Running ☐ Water sports ☐ Hiking ☐ Contact sports ☐ Other

May participate in Special Olympics: ☐ *Yes* ☐ *No*
Other Comments:

Next completed physical should be completed in _____years.

_____
(Physician's Signature)

_____
(Date Signed)

Copies: Original to SC file Provider-Day_____ ☐ Provider-Res_____ ☐