Target Community & Educational Services, Inc.
...Targeting Dreams, Fostering Opportunities
www.targetcommunity.org

111 Stoner Avenue
Westminster, Maryland 21157
Ph: 410-848-9090 Fax: 410-848-7409

18403 Woodfield Road
Gaithersburg, MD 20879
Ph: 240-632-1434 Fax: 240-632-1189

# Annual Health Summary

## Part One: To be completed by Target Employee prior to the visit

_____ _____
Last Name First Name Middle Date

_____
Address City/County

_____
State Zip

_____ _____
Telephone # Date of Birth

## Health History of Past Year

**X** in the box = Yes

- ☐ Serious Head Injury
- ☐ Difficulty with Vision
- ☐ Wears Glasses
- ☐ Difficulty with Hearing
- ☐ Wears Hearing Aid
- ☐ Frequent Nose Bleeds
- ☐ Ear Infections
- ☐ Dental Extractions
- ☐ Sore, Bleeding Gums
- ☐ Frequent Sore Throats
- ☐ Frequent Colds
- ☐ Pneumonia/Bronchitis
- ☐ Hernia
- ☐ Skin Lesions
- ☐ Psychiatric Disorder
- ☐ Unsteadiness in Walking
- ☐ Unusual Weight Loss
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Severe Indigestion
- ☐ Frequent Vomiting
- ☐ Constipation
- ☐ Frequent Diarrhea
- ☐ Bowel Incontinence
- ☐ Urine Incontinence
- ☐ Kidney Disease
- ☐ Gynecology Problems
- ☐ Venereal Disease
- ☐ Arthritis
- ☐ Fractures
- ☐ Seizures
- ☐ Unusual Weight Gain

**Remarks: (If you responded 'yes' to any question, please give details.)**

_____
_____
_____
_____
_____
_____
_____

**Hospitalizations / Operations (Location, Dates and Details)**

**Accidents / Injuries (Dates, Description)**

| Medications & Dosage | Prescribing Physician |
|---|---|
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Signature and Title of Employee Completing Form

Date

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# Annual Physical Examination Form

## Part II: To be completed by the Health Care Professional

Name: _____ Date: _____

Blood Pressure Right: _____ Left: _____ Weight: _____
Height: _____ Temperature: _____ Pulse: _____ Respirations:_____

General Appearance: _____
Nutritional Status: _____

1. Head: _____ Skin: _____
2. Eyes/Vision Screening: Right Eye: _____Left Eye: _____
   Test Used: _____
   Conjunctiva _____ Sclera _____ Cornea _____
   Pupils: _____ Lens _____ Fundi _____
3. Ears/Auditory: Right: _____ Left: _____ Bilateral: _____
   Test Used: _____
   Canals _____ Drums _____
4. Nose: _____
5. Mouth (Gums, Tongue): _____
6. Teeth: _____
7. Pharynx: _____
8. Neck: _____
9. Thyroid Gland: _____
10. Lymph Nodes: _____
11. Chest: _____
12. Lungs: _____
13. Heart: _____
14. Breasts: _____
15. Abdomen:_____
16. Genitalia: _____
17. Rectal:_____
18. Extremities:_____
19. Neurological:_____
    Orientation: _____
    State of Consciousness: _____
    Cranial Nerves: _____

DTR: _____
Pathological Reflexes: _____
Muscle Strength: _____
Gait: _____
Tone: _____
Involuntary Movements: _____

20. Joints (Contractures): _____
21. Spine (Describe and Curvature): _____
22. Tardive Dyskinesia screening indicated if client receives Behavior Modifying Drugs at the time of the examination or has received them in the past year.
    Use Tardive Dyskinesia Screening Form to document evaluation.

Diagnosis:_____
_____
_____
_____
_____
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Recommendations:
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_____ _____
Signature of Health Care Professional Date

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# Annual Physical Examination
## Immunizations

## Part III: To be completed by the Health Care Professional

**Client's Name**: _____ **Date**: _____

**Diet Order from Health Care Professional**
Directions: Please check one and specify.
Regular Diet: ☐ Yes ☐ No Special Diet: ☐ Yes ☐ No

If a special diet, explain:_____

Dietary Restrictions: ☐ Yes ☐ No If yes, explain: _____
_____
_____
_____

**PPD Injection Date**: _____ **Results** (Check one): ☐ Positive ☐ Negative
**If indicated, Chest X-Ray Date** / Results:_____
**Tetanus / Diphtheria Booster** Date Administered:_____
**Hepatitis B Vaccine**
Dose #1 (initial) _____
Dose #2 (1 month after 1st)_____
Dose #3 (5-6 months after 1st)_____

**Laboratory Studies**
**Urinalysis** Date: _____
Sugar ☐ Negative ☐ Positive
Protein ☐ Negative ☐ Positive

Additional Comments:_____

**Liver Function Test (LFT)**
*LFT should be performed annually if the client is receiving or has received in the past year, behavior modifying drugs and/or anticonvulsant medications.

**LFT Date** / Results: _____