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

438 N. Frederick Ave. Suite 325
Gaithersburg, MD 20877
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)

_____
_____
_____

Current Medication List: See Attached Medication Face Sheet

_____ _____

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): _____

Diagnosis:_____
_____
_____
_____
_____

Recommendations:
_____
_____
_____
_____
_____
_____
_____

_____ _____
Name of Health Care Professional (Printed) Office Number

_____ _____
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: _____