PHYSICAL APPRAISAL FORM

Patient Name _____
Patient DOB _____ M ____ F ____

RELEASE OF GENERAL MEDICAL INFORMATION: By signing this form, I understand that I am authorizing the release of medical information concerning me to the appropriate Probate Court and other Institutions, agencies, and Interested Individuals for the purpose of determining and providing appropriate care to me.
Signature of Patient or Legal Guardian, Title and Date
RELEASE OF HIV/AIDS/ARC INFORMATION: By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immunodeficiency Syndrome, AIDS Related Complex, or Human Immunodeficiency Virus, if applicable, to the appropriate Probate Court and other institutions, agencies, and interested individuals for the purpose of determining and providing appropriate care for me.
Signature of Patient or Legal Guardian, Title and Date

Diagnoses
Current Medications, Dosages and Instructions
Past Medical and Surgical History
Family History
Habits (alcohol, tobacco, drugs, coffee, etc.)
Allegies/Sensitivities and Manifestations
Ht_____ Wt_____ B/P_____ T_____ P_____ R_____ Ideal Weight Range_____
Recommended Diet / Special Instructions

CONTINUED ON OTHER SIDE

Patient Name _____

REVIEW OF SYSTEMS			
Within Normal Limits?	YES	NO	Describe All Abnormalities
Integument			
Head and Neck			
Eyes			
Ears			
Mouth, Nose and Throat			
Thorax – Breast			
Heart			EKG – Y/N
Lungs			CXR – Y/N
Abdomen			
Reproduction			
Genito-urinary			
Endocrine			
Extremities			
Muscle-Skeletal			
Neurological			
Mobility/Ambulatory Status			
TB Skin Test			Recheck Date:
Susceptibility to Hyper/ Hypothermia			
Other Problems or Limitations Acute (requiring attention)			
Chronic (requiring ongoing attention)			
Recommendations			

_____ _____
Examining Physician's Signature Date

_____
Print Physician's Name

_____
Address

_____
Telephone Number