San Gabriel / Pomona Regional Center

PHYSICAL EXAM

Patient Identification

Patient Name:			Date of Exam:	
Physician's Name:		UCI#	SS#	
Sex:	DOB:	Age:	Height:	Weight:

GENERAL HEALTH	☐ Good	☐ Fair	☐ Poor
AUDITORY IMPAIRMENT	☐ No	☐ Yes	*Explain:*
VISUAL IMPAIRMENT	☐ No	☐ Yes	*Explain:*
ALCOHOLIC PROBLEMS	☐ No	☐ Yes	*Explain:*
SPECIAL DIET	☐ No	☐ Yes	*Specify:*
MEDICATIONS	☐ No	☐ Yes	*Specify:*
TUBERCULOSIS EXAMINATION	☐ Active	☐ Inactive or None	*Date of Exam:*
OTHER CONTAGIOUS OR INFECTIOUS DISEASES	☐ None	☐ Yes	*Explain:*
HEAD (eyes, ears, nose, throat)			
HEART (arrhythmia)			
LUNGS (breath sounds)			
CHEST (breasts)			
ABDOMEN (kidneys, spleen, liver)			
ADENOPATHY (neck, axilla, groin)			
GENITALIA (pelvic)			
RECTAL			
MUSCULO SKELETAL			
NERVOUS SYSTEM			

SUMMARY OF FINDINGS
(For residents, include diagnosis. For service providers, describe limitations on physical abilities.):

_____ _____ _____

Physician Name (please print) **Physician's Signature** **Date**

For Clients in Residential Placement Only

Check one

	YES	NO	COMMENTS
Bathes self			
Dresses self			
Feeds self			
Cares for own toilet needs			
Is able to care for all personal needs			
Can administer own medication			
Needs help with medication			
Medication prescribed and instructions given to patient **(please specify)**			

IMPORTANT: ☐ AMBULATORY ☐ NON-AMBULATORY*

***NON-AMBULATORY** means that the individual is unable to leave a building unassisted under emergency conditions. It includes any person unable, or likely unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshall, or an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walker, and wheelchairs. If NON-AMBULATORY is marked, facility must have a "non-ambulatory" clearance on the license.

_____ _____ _____
Physician Name (please print) **Address** **Telephone Number**

_____ _____
Physician Signature **Date**