Champlain Community Services
512 Troy Ave, Suite 1
Colchester, VT 05446
802-655-0511 (P) 802-655-5207 (F)

Annual Physical Examination

Client Name:_____ DOB:_____ Date: _____

List of current medical problems: or ☐ see attached

Temp:_____ Pulse:_____ Respiration:_____ Blood Pressure: _____ Height: ____ Weight: _____

☐- these items listed on "After Visit Summary," see attached form.

Physical Findings:

System	Negative Findings "✓"	Positive Findings : please describe
Skin		
Eyes		
Ears		
Nose		
Mouth/teeth		(if edentulous – please do oral exam)
Neck/thyroid		
Lymph Nodes		
Respiratory		
Abdomen		
Extremities		
Reflexes		
Musculo-skeletal		
Cardiovascular		
Genitalia		

Rectum		
Prostate		
Breasts		

Pap test: ☐ done *or* ☐ not applicable due to gender or _____

Mammogram ☐ ordered *or* ☐ not applicable, not due

☐ vision & hearing appear WNL ☐ vision and hearing sub-optimal – referral to specialist made

Lab Work Ordered:_____

Other Referrals Made: _____

_____ _____

PHYSICIAN SIGNATURE PHYSICIAN NAME (print) & DATE

_____ _____

STAFF SIGNATURE STAFF NAME (print) & DATE

Champlain Community Services

Medication List

Client's Name: _____ **DOB:** _____

Allergies: _____

Physician's Name: _____

Medication Name	Dose	Route	Frequency	Reason for Taking

All prescriptions need to be reviewed by a Physician annually.

Physician's Signature: _____ Date: _____

Service Coordinator's Signature: _____ Date Received: _____

Agency Nurse's Signature: _____ Date: Received: _____

Guardian Notified and Approves: _____ Date Notified: _____