



Medical Services Department

P.O. Box 250 Johnstown, PA 15907
(814) 536-2111 Fax (814) 539-2871

Physical Examination Form
To be completed by a Licensed Physician

CLIENT INFO:

Name of Patient _____
Last First Middle Initial

Home Address _____
Street Apt# City State Zip Code

Telephone (home) _____ (cell) _____

Date of Birth _____ Age _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Race: African American Native America
Asian Hispanic
Bi Racial Pacific Islander
Caucasian Other

Client's General Appearance: _____

Client's Vitals: Temp: _____ Pulse: _____ Resp: _____ BP: _____

Height: _____ Weight: _____

ADDICTION:

Alcohol Yes No Explain if yes _____
Heroin Yes No Explain if yes _____
Eating Disorder Yes No Explain if yes _____
Marijuana Yes No Explain if yes _____
Cocaine Yes No Explain if yes _____
Nicotine Yes No Explain if yes _____
Prescription Pills Yes No Explain if yes _____
Other (Specify) Yes No Explain if yes _____

CURRENT MEDICATIONS:

Is client currently taking any prescribed medication? Yes No If yes please list:

Medication	Dosage	Date Prescribed	Prescribed For

Review of Systems	WNL	Abnormal Findings
Head		
Ears		
Eyes		
Nose		
Throat		
Neck		
Lymph Nodes/Thyroid		
Lungs		
Cardiac		
Abdomen		
Genitourinary		
Musculoskeletal		
Extremities		
Neuro Assessment (CN1-XII)		

ITEM TO BE CHECKED	YES	NO	IF YES, PLEASE EXPLAIN
Allergies to Food/Drugs			
Immunizations up to date (Tetanus)			
Asthma			
Chicken Pox			
CXR			
Diabetes			
German Measles			
Hypertension			
Measles			
Mumps			
Sexually Transmitted Disease			
Surgeries			
TB Test and results			

FEMALES ONLY: _____

Menstrual Onset: _____ Date of Last Menstrual: _____

PMS: _____ Remedy: _____

The following tests are mandatory for admittance.

To speed client admission process, please send all blood test and X-Ray results to address below.

TEST TO BE COMPLETED	DATE COMPLETED	SIGNATURE OF RESPONSIBLE PARTY
Complete blood count with differential (CBC w/Diff)		
Serology (RPR- Syphilis)		
Hepatitis Screening		
HIV Screening		
Urinalysis Routine		
PPD		
CXR (if Applicable)		

**PENIEL
ATTEN: MEDICAL SERVICES DEPARTMENT
P.O. BOX 250
JOHNSTOWN, PA 15907**

PHYSICIAN STATEMENT:

I have examined _____ and have found no conditions that would prevent him/her from being admitted or performing any assignments. This client is free of any communicable diseases. Should there be any restrictions, please refer to the Recreation Release Form. Should any blood test results return and need further attention, the Medical Services Department will be notified and proper protocol will be addressed.

Licensed Physician Signature

Date