Madison County 310 Board

**ANNUAL PHYSICAL EXAMINATION**

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female Height\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight Gain/Loss Indicated: \_\_\_\_\_\_\_\_\_\_\_

Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ T\_\_\_\_\_\_\_\_\_\_ B/P\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Seizure Disorder Yes No Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL EXAMINATION: (Should include, but not limited to the following):

* SKIN

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* HEAD/SCALP

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* EYES

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NOSE

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* EARS

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* MOUTH/THROAT

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NECK

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* CHEST/LUNGS

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* HEART/PERIPHERAL CIRCULATION

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* BREAST

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ABDOMEN

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* GENITALIA

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* RECTAL

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* EXTREMITIES

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* SPINE

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* NEUROLOGICAL

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ENDOCRINE

\_\_\_\_\_\_Normal \_\_\_\_\_\_Abnormal

Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPRESSIONS AND RECOMMENDATIONS**

* Summary of Abnormal Findings
* Diagnostic Impressions

* Limitations Affecting Physical Activities
* Recommendations (Include any specialized consultations if desired)

Immunization Status:

TB Test DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RESULTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus Vaccine Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza Vaccine Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN/CRNP SIGNATURE DATE**

**STANDING ORDERS**

The following medication may be given to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ while participating in a day habilitation program or residential service. **PHYSICIANS PLEASE CIRCLE THOSE MEDICATIONS WHICH ARE APPROVED FOR THIS INDIVIDUAL.**

1. **CONSTIPATION PREVENTION:** Stool Softener

METAMUCIL (Sugar Free)

Directions: a) Fill standard 8 oz. glass with cool water

b) Sprinkle a rounded teaspoon of Metamucil powder into the liquid

c) Stir briskly and drink immediately followed by an additional 8oz of liquid

d) Take 1-3 times daily (may need to take 3x’s daily for 2 days, then 1 or 2x’s daily routinely)

1. **SEVERE CONSTIPATION:** Laxative

MILK OF MAGNESIA

Directions: Shake well. Adults: Give 2-4 tablespoons followed by a glass of water, one dose

only. Notify physician if results are not satisfactory and Nurse after 3 days *WARNING:* Not to be used when abdominal pain, nausea, vomiting or other symptoms of appendicitis are present.

1. **UPSET STOMACH/INDIGESTION**

PEPTO BISMOL

Directions: Shake well. Adults: Give 2 tablespoons. Repeat every 30 minutes to 1 hour if needed, up to 8 doses within a 24 hour period.

MAALOX OR MYLANTA

Directions: Give 15ml. (One tablespoon) between meals or at bedtime. Notify Supervisor or RQMRP if more than 3 doses are given in a 24 hour period.

1. **NAUSEA**

EMETROL

Directions: Adults: Give 1-2 tablespoons every 15 minutes until distress subsides. Not to be taken for more than 1 hour (5 doses) without consulting a physician.

1. **DIARRHE**A

IMMODIUM A.D.

Directions: Adults: Give 2 caplets after first loose bowel movement and 1 caplet after each

subsequent loose bowel movement, but no more than 4 caplets daily for 2 days.

1. **MINOR CUTS & ABRASIONS**

NEOSPORIN

Directions: Used to prevent infections in minor cuts, burns, and abrasions as an aid in healing. Clean affected area well. Apply directly to the affected area and cover with sterile gauze if necessary. May be applied 2-5 times daily for no longer than 3 days. If redness, irritation, swelling, or pain persists or increases, or infection occurs, discontinue use and consult a physician. Do not use in eyes.

1. **FUNGUS INFECTIONS, ATHLETE’S FOOT, JOCK ITCH, OR RING WORM**

TINACTIN CREAM

Directions: Wash and dry affected area morning and evening. Apply ½ inch ribbon of cream and rub gently on the affected area. Spread evenly. To prevent reoccurrence, continue treatment for 2 weeks after disappearance of all symptoms. *CAUTION:* If burning or itching does not improve within 10 days or becomes worse, discontinue use and consults a physician. For external use only. Keep out of eyes. Not for nail, scalp, or ear infections.

1. **HEADACHE**

ACETAMINOPHEN (500MG)

Directions: Take 1 tablet 3-4 times daily for 48 hours.

1. **ALLERGY SYMPTOMS**

BENADRYL

Directions: Give 1 capsule every 6 hours not to exceed 4 capsules in a 24 hour period of time, for relief of runny nose, sneezing and itching of the nose and throat, and itchy, watery eyes due to hay fever or upper respiratory allergies. Notify Nurse or RQDDP

1. **COUCH AND COLD SYMPTOMS**

ROBITUSSIN (Alcohol and Sugar Free)

Directions: Give 2 teaspoons every 4 hours as needed for cold and cough symptoms. Notify Nurse or QDDP if coughing persists after 24 hours or if coughing is accompanied with fever or other complaints.

1. **CLEANING OF MINOR CUTS AND ABRAISIONS**

HYDROGEN PEROXIDE

Directions: Use to clean minor cuts and abrasions. If irritation, swelling or pain persists or if infection is suspected notify Supervisor or RQMRP.

1. **CONTACT DERMATITIS**

CALAMINE/CALADRYL LOTION

Directions: Apply liberally to the skin as often as necessary. If symptoms persist after 24 hours, notify

Supervisor or RQMRP.

1. **FEVER OR PAIN**

TYLENOL (Extra Strength)

Directions: Give 2 tablets every 6 hours. Notify Supervisor or RQMRP if more than 3 doses given in a 24 hour period.

IBUPROFEN

Directions: Adults: Take 1 tablet every 4-6 hours while symptoms persist. If pain or fever does not respond to 1 tablet, 2 tablets may be used. Do not exceed 6 tablets in 24 hours, unless directed by a physician. The smallest effective dose should be used.

*ALLERGY ALERT:* Ibuprofen may cause a severe allergic reactions which may include: \*Hives \*Facial Swelling \*Asthma (wheezing) \*Shock

1. **SUN PROTECTION**

SUNSCREEN

Directions: Apply to exposed areas of the skin. Do not apply around the eyes. Contact physician if fever, blisters, or extreme pain are present due to sunburn.

1. **RECTAL ITCHING**

TUCK’S PADS

Directions: Instruct resident to apply to outer rectal/vaginal area to relieve external discomfort. FOR EXTERNAL USE ONLY! In case of rectal bleeding, notify Supervisor or RQMRP. If problems persist after 24 hours notify Supervisor or RQMRP.

1. **DECONGESTANT**

SUDAFED

Directions: Give 2 tablets every 6 hours not to exceed 4 doses in a 24 hour period.

**DO NOT GIVE TO A RESIDENT WHO HAS HIGH BLOOD PRESSURE!!!!!!** Notify Supervisor or RQMRP after 24 hours if problems persist.

1. **IRRITATED THROAT**

CHLORASEPTIC SPRAY

Directions: Spray 5 times and swallow. May repeat every 2 hours if necessary. Notify Supervisor or RQMRP if problems persist.

1. INFLUENZA VACCINE 0.5ml IM annually.
2. TUBERCULIN TEST 0.1ml subcutaneous annually or PRN.
3. Pneumococcal Vaccination 0.5 mL intramuscularly or subcutaneously – every 5 years

\*ANYTIME THESE MEDICATIONS ARE USED THE NAME OF THE MEDICATION, AMOUNT, AND TIME GIVEN, REASON FOR GIVING MEDICATION AND RESULTS MUST BE RECORDED ON THE DAILY CARE RECORD SHEET AND SIGNED BY THE STAFF PERSON WHO ASSISTED THE RESIDENT.\*

CONTACT NURSE/QDDP PRIOR TO GIVING ANY OTC MEDICATIONS!

\*\*\*\*\*\*\*\*\*MAY USE GENERIC EQUIVALENTS\*\*\*\*\*\*\*\*\*\*

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PHYSICIAN’S SIGNATURE DATE