WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

General Physical (Adults)

This report can be made available to the patient or representative upon request.

MA ID/Pending Medicaid No.: _____ DHHR Office: _____

PATIENT: _____ SSN: _____
Last First Middle

Date of Birth: _____ Sex: Male: _____ Female: _____

Customary Occupation: _____

If currently under a physician's care, give name of physician and reason for care: _____
_____

Date Referred: _____ Return Form to: _____

PHYSICAL EXAMINATION (Must be completed in full)

A. Applicant's Statement of Incapacity/Disability: _____
_____

B. Measurements and Findings:
Height: _____ Weight: _____
Temp.: _____ Pulse: _____
Blood Pressure: Systolic: _____ Diastolic: _____
Speech: _____
Posture: _____
Gait: _____

Distant Vision Without Glasses:
Right Eye: 20/ _____ Left Eye: 20/ _____
Distant Vision With Glasses:
Right Eye: 20/ _____ Left Eye: 20/ _____
Eyes: Other than Vision _____
Ears: Right _____ Left: _____
Ears: Other than Hearing _____

C. After examination, check if NORMAL and comment if findings are ABNORMAL:

_____	1. Mouth and Teeth	_____
_____	2. Nose and Throat	_____
_____	3. Neck	_____
_____	4. Lymphatic system	_____
_____	5. Breasts	_____
_____	6. Lungs and Chest	_____
_____	7. Heart	_____
_____	8. Abdomen	_____
_____	9. Hernia	Type: _____ Reducible: Yes: _____ No: _____
_____	10. Varicose Veins	_____
_____	11. Edema (sites)	_____
_____	12. Neurological	_____
_____	13. Psychiatric	_____
_____	14. Orthopedic	_____
_____	15. Arteriosclerosis	_____
	(COMPLETE IF INDICATED)	_____
_____	16. Genito-Urinary	_____
_____	17. Gynecological	_____
_____	18. Ano-rectal	_____

D. Describe in detail any pain:_____

_____

E. Diagnosis:

Major:_____ Minor:_____

_____ _____

F. Applicant's ability to work full time:

1. Is applicant able to work full time at customary occupation or like work: Yes:____ No:____

Explain:_____

_____

2. Is applicant able to perform other full time work: Yes:_____ No:_____

Explain_____

_____

3. What work situations, if any, should be avoided:_____

4. Duration of inability to work full time: One month_____ Six months_____ One year_____

Other_____ Explain:_____

_____

G. Recommendations for further tests or treatment:

1. Diagnostic Tests:_____

_____

2. Specialist's Consultations: _____

_____

3. Treatment (Specify type):_____

_____

H. Should applicant be referred for vocation rehabilitation? Yes:_____ No:_____

I. Summary of Conclusions:

J. _____ _____

Date of Examination Examining Physician's Signature

_____

Printed Name of Physician