DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE

RESIDENT ANNUAL PHYSICAL EXAMINATION RECORD

Name: ______________________ Birth date: ______________

Address: ____
Number Street Name City Island Zip Code

Height: __________ Weight: __________ B/P: __________

Eyes: __________ Pupils: __________ Ears: __________

VISION: Right: __________ CORRECT VISION: Right: __________ HEARING: Right: __________

Left: __________ Left: __________ Left: __________

Nose: __________ Mouth: __________ Teeth: __________ Thyroid: __________

HEART: Rate: __________ Rhythm: __________ Murmurs: __________

Lungs: __________ Nervous System: __________

Abdomen: __________ Kidneys: __________

Genitalia/Pelvis: __________ Hemorrhoids: __________

Varicosities: __________ Hernia: __________

Skin: __________ Romberg: __________ Reflexes: __________

Extremities: Upper: __________ Lower: __________

Other abnormalities: ____

____

Current medications, if any: ____

____

Resident is ambulatory and capable of following directions and taking appropriate action for self preservation under emergency conditions: ☐ Yes ☐ No

Diagnosis: ____

____

Diet: ____

____

Level of Care Assessment:
The Resident is certified as: ☐ **Independent** ☐ **ARCH** ☐ **ICF** ☐ **SNF**

______________________ ______________________ __________
Print or Type Physician/APRN Name Physician/APRN Signature Date

OHCA
ARCH I R 19 B
01/07