

**FUTURES COMMUNITY SUPPORT SERVICES, INC.**  
**ANNUAL PHYSICAL FORM**  
**6500 Regulations (Family Living)**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

\*\*\* If the person attends ATF \*\*\*

Please make sure a copy is forwarded to the day program and county supports coordinator.

**6500.121. INDIVIDUAL PHYSICAL EXAMINATION**

6500.121.(c) (1) Review of previous medical history.

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6500.121.(c) (2) General Physical Examination

6500.121.(c) (3) Immunization for individuals 18 years of age or older as recommended by the United States Public Health Services.

DT                      Yes \_\_\_\_\_                      No \_\_\_\_\_                      Date: \_\_\_\_\_

RECOMBIVAX        Yes \_\_\_\_\_                      No \_\_\_\_\_                      Date: \_\_\_\_\_

Carrier no Antibodies \_\_\_\_\_

6500.121.(c) (4) Vision and hearing screening for individuals 18 years or older recommended by the physician.

**VISION SCREENING:**

Distant Vision:        Without Glasses                      Right: \_\_\_\_\_                      Left: \_\_\_\_\_

                                 Without Glasses                      Right: \_\_\_\_\_                      Left: \_\_\_\_\_

**HEARING SCREENING:**

Ordinary Conversation:        Right \_\_\_\_\_ /15                      Left \_\_\_\_\_ /15

Results: \_\_\_\_\_

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6500.121.(c) (5) Immunizations and screening tests for individuals 17 years of age or younger, as recommended by the Standards of Child Health Care of the American Pediatrics.

Can be done on above regulation (3) & (4).

6500.121. (c) (6) Tuberculin skin testing by Mantoux method with negativity results every 2 years for individuals 1 year of age or older; or if tuberculin skin test is positive, an initial x-ray with results noted.

TB Mantoux Method: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

6500.121.(c) (7) A Gynecological examination including a breast examination and a Pap test for women 18 years of age or older, unless there is documentation from a licensed physician recommending no or less frequent gynecological examinations.

Gynecological Exam: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

6500.121.(c) (8) A mammogram for women at least every 2 years for women 40 through 49 years of age and at least every year for women 50 years of age or older.

Mammogram: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

6500.121(c) (9) A prostate examination for men 40 years of age or older.

Prostate Exam: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_  
\_\_\_\_\_

6500.121.(c) (10) Specific precautions that must be taken if the individual has a communicable disease to prevent spread of the disease to other individuals.

Communicable Disease:      Yes: \_\_\_\_\_      No: \_\_\_\_\_      Date: \_\_\_\_\_

Precautions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6500.121.(c) (11) An assessment of the individual's health maintenance needs, medication regimen and the need for blood work at recommended intervals.

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

6500.121.(c) (12) Physical limitations of the individuals.

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

6500.121.(c) (13) Allergies or contraindicated medications.

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

6500.121.(c) (14) Medical information pertinent to diagnosis and treatment in case of emergency.

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

6500.121 (c) (15) Special instructions for the individual's diet.

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

6500.121 (b)

Physician Signature: \_\_\_\_\_      Date: \_\_\_\_\_

# PHYSICIAN RECOMMENDS OTC LIST

Individual's Name: \_\_\_\_\_

Program: \_\_\_\_\_

Date: \_\_\_\_\_

Over-the-Counter drugs individual should use for the following problems:

Date D/C and initial

\_\_\_\_ 1. Upset Stomach/Thrown Up: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 2. Diarrhea: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 3. Cold/Runny Nose: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 4. Cough: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 5. Fever: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 6. Constipation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 7. Headache: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 8. Minor Aches and Pains: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 9. Menstrual Cramps: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 10. Other: \_\_\_\_\_

(Please see reverse side for additional OTC Medications)

\_\_\_\_ May Substitute with generic. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\*Refer to OTC equivalent reference list.

Over-The-Counter drugs should be used for the following problems:

Date D/C  
and initial

\_\_\_\_ 11. Other Conditions (please specify): \_\_\_\_\_

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\_\_\_\_ 12. Other Conditions (please specify): \_\_\_\_\_

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\_\_\_\_ 13. Other Conditions (please specify): \_\_\_\_\_

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\_\_\_\_ 14. Other Conditions (please specify): \_\_\_\_\_

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\_\_\_\_ 15. Other Conditions (please specify): \_\_\_\_\_

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\*\*\*\*\* Reminder: Print and attach the MA 51 form to this document\*\*\*\*\*