Annual Physical

Information required by ODDD

Choices In Community Living, Inc.
1651 Needmore Road
Dayton, Oh 45414
937-898-2220

Name_____ Birthdate_____ Exam Date_____

TO BE COMPLETED BY THE PHYSICIAN

Height_____ Temp_____ Blood Pressure_____
Weight_____ Pulse_____ Respirations_____

	Normal? √ = yes	Comment		Normal? √ = yes	Comment
Eyes			Circulatory		
Ears			Skin		
Nose			Genitalia		
Throat			Rectum		
Mouth			Pelvic		
Head/Neck			Extremities		
Breast			Back		
Abdomen			Heart		

Testing Ordered:

Urinalysis_____ Pap_____
BMP_____ Mammo_____
CBC_____ Other_____

Diagnosis and Treatment: _____

_____

New Medications or **Medication Changes** prescribed this visit:
Written instructions are required by ODDD

Medication	Instructions Specify frequency, dosage, and duration	Diagnosis Reason for giving the med

Cannot prescribe "apply to affected area." Please state which area medication is to be applied.
Cannot prescribe medication in a range (1-2 pills every 4-6 hrs). Must be specific (2 pills every 6 hrs)

Discontinued Medications: Please provide a date the med should be discontinued.

Medication	Date

Physician's signature: _____

TO BE COMPLETED BY CICL STAFF

Current Medications: See attached. Please check one box

☐ Current Physician's Orders ☐ Current MAR ☐ Brought Meds

* Physician's orders should be signed by the doctor every three months and turned into the pharmacy.

Allergies (Include Medications): _____

_____

Significant Medical History (Include any hospitalizations, treatments, etc.): _____

_____

_____

Current Medical Concerns (behavior changes, medications, questions, etc.): _____

_____

_____

Any Additional Information? _____

_____

CICL Staff's Summary of the Visit: _____

_____

_____

_____

_____

Physician's Name (Please Print) _____

Address _____

Phone Number _____

Next Appointment Scheduled: _____

Staff's Name (Please Print) _____

Accompanying Staff's Name (Please Print) _____

Name:_____ Date:_____

Check which over the counter medication this individual may use as needed:

Please make changes as needed:

Pain or Temperature

_____ **Tylenol (Acetaminophen)** take two 325mg tablets, by mouth, every 4 hours, not to exceed 12 tablets in 24 hours, as needed, for general pain (not including stomach pains), headache, or temperature over 100 degrees Fahrenheit taken by an oral or temporal device

_____ **Other** (describe)_____

Laxative

_____ **Milk of Magnesia** 30ml by mouth at bedtime, as needed, not to exceed 60cc in 24 hours, give after three days of no bowel movements, to produce a bowel movement. Call RN if medicine does not produce a bowel movement.

_____**Other**_____

Cough

_____**Robitussin DM**, 10ml, by mouth, every 4 hours, as needed, for non-productive cough, not to exceed 6 doses in 24 hours, if cough persists for 5 days, without a fever, call MD to make appointment.

_____**Other**_____

Diarrhea

_____**Imodium AD** 2mg tablets, take 2 tablets (4mg), by mouth, after first loose watery stool then, one tablet (2mg) after each subsequent loose stool, as needed for loose watery stools, not to exceed 4 tablets in 24 hours. If loose watery stools continue despite medication, call MD for appointment.

Other:

_____May use **Triple Antibiotic Cream/Ointment** apply to affected area(s) topically three times a day, as needed, for areas of broken skin, if not improved in 7 days call doctor for appointment

Caffeine and Alcohol

_____Individual may consume beverages and/or items containing caffeine.

_____Individual may consume beverages containing alcohol.

_____Additional information:_____

____**Other**_____

Dietary Guidelines:_____

_____

Work Limitations:_____

_____

Physician's Signature:_____Date:_____