Peniel
Medical Services Department
P.O. Box 250 Johnstown, PA 15907
(814) 536-2111 Fax: (814) 539-2871

Physical Examination Form
To be completed by a Licensed MD/PA/NP

Name of Patient: _____
Last First Middle Initial

Home Address: _____
Street Apt # City State Zip Code

Telephone: (H) _____ (C) _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Sex: Male ☐ Female ☐ **Marital Status:** Single ☐ Married ☐ Divorced ☐ Widowed ☐

Race:
African American ☐
Asian ☐
Bi Racial ☐
Caucasian ☐
Native American ☐
Hispanic ☐
Pacific Islander ☐
Other ☐

Client's General Appearance: _____

_____

Client's Vitals: Temp: _____ Pulse: _____ Resp: _____ BP: _____

Height: _____ Weight: _____ Allergies: _____

<u>Labs To Be Completed</u>: Please fax results as soon as possible To prevent double billing and testing Fax: (814) 539-2871

Complete blood count with Differential (CBC w/Diff) ☐
Serology (RPR- Syphilis) ☐

HIV Screening ☐
PPD Pos ☐ Neg ☐

Acute Hepatitis Panel
Hep A IgM, Hep B Core Igm, Hep B surf, Hep C AB LF, HCVRNA, GHCV ☐

Date Read: _____
CXR (if applicable): _____

Current Medications

Medication	Dosage	Date Prescribed	Prescribed for

REVIEW OF SYSTEMS	WNL	ABNORMAL FINDINGS
Head		
Dental (Last exam:)		
Ears		
Eyes (Last exam:)		
Nose		
Throat		
Neck		
Lymph Nodes/Thyroid		
Lungs		
Cardiac		
Abdomen		
Genitourinary		
Musculoskeletal		
Integumentary		
Neuro Assessment (CN1-XII)		

PAST MEDICAL HISTORY	YES	NO	IF YES, PLEASE EXPLAIN
Allergies to Food/Drugs			
Immunizations up to date			
Asthma			
Chicken Pox			
Meningitis/Mono			
Diabetes			
GERD			
Hypertension			
Measles			
Mumps			
Sexually Transmitted Disease			
Surgeries			

FEMALES ONLY:

Discharge/Burning/Itching: _____ Genital Warts: _____

Menstrual Onset: _____ Date of Last Menstrual: _____

# of Pregnancies: _____ # of Children: _____ # of Miscarriages _____ # of Abortions _____

Last Exam (including PAP/Mammogram): _____

MALES ONLY:

Discharge/Burning/Itching _____Genital Warts: _____

Testicular swelling/pain: _____

FAMILY HEALTH HISTORY: *Have any of your family members ever had:*

Condition		Family Member	Condition		Family Member
Alcoholism/Drugs	☐		Mental Health Disorders	☐	
Arthritis	☐		Diabetes	☐	
Colitis	☐		Heart Disease	☐	
Cancer	☐		Heart Attack	☐	
Sickle Cell	☐		Stroke	☐	
Kidney Disease	☐		Tuberculosis	☐	
Thyroid	☐		Bleeding Tendency	☐	
Epilepsy	☐		Suicide Attempts	☐	
Migraine	☐				

SOCIAL HISTORY: Habits / Addictions

Cigarettes ☐ Packs/ Day _____ Last use: _____ Used ( ) Mo/Yrs
Smokeless Tobacco (chew/snuff) □ Cans/day _____ Last use: _____ Used ( ) Mo/Yrs.

Alcohol (Liquor) ☐ Amount: _____ Last use: _____

Beer ☐ Amount: _____ Last use: _____

Heroin ☐ IV use (Circle) Yes /No Amount: _____ Last use: _____

Marijuana ☐ Organic / Synthetic (Circle One or Both) Amount: _____ Last use: _____

Cocaine/ Crack (Circle One or Both) ☐ Type: _____ Amount: _____ Last use: _____

Meth ☐ Type: _____ Amount: _____ Last Use: _____

Bath Salts ☐ Type: _____ Amount: _____ Last Use: _____

Prescription Pills ☐ Type: _____ Amount: _____ Last Use _____

Type: _____ Amount: _____ Last Use: _____

Ecstasy ☐ Type: _____ Amount: _____ Last Use: _____

Hallucinogens ☐ Type: _____ Amount: _____ Last Use: _____

Inhalants ☐ Type: _____ Amount: _____ Last Use: _____

Other: ☐ Type: _____ Amount: _____ Last Use: _____

Emotional/Mental/Psychiatric Health:

Check any of the following which you have had. List age symptoms began.

☐ Depression- Age: ____ ☐ Bipolar Disorder- Age: ____ ☐ ADD- Age: ____ ☐ Seizures- Age:

☐ Anxiety- Age: ____ ☐ Personality Disorder- Age: ____ ☐ ADHD- Age: ____ ☐ Sexual Addiction- Age

☐ Phobias- Age: ____ ☐ Mood Disorders- Age: ____ ☐ PTSD- Age: ____ ☐ Self-Mutilation

☐ Schizophrenia- Age: ____ ☐ Eating Disorder- Age: ____ ☐ OCD- Age: ____ ☐ Blackouts- Age:
Drug related? N Y

PHYSICIAN STATEMENT:

I have examined _____ and have found no conditions that would prevent him/her from being admitted into residential dormitory settings. This client is free of any communicable diseases.

_____ _____
Licensed Physician Signature Date