Kansas Department for Children and Families
Rehabilitation Services

7/93

MEDICAL EXAMINATION

Name _____ Date of Birth _____

Address _____Phone _____

Education_____ Usual Occupation_ _____ Date of last Employment_____

Personal Physician_____ Address _____ Phone _____

The above named individual has applied to Rehabilitation Services to help in achieving employment and independence. An appraisal of general health is needed to identify any limitations of functioning that might have vocational implications.

History

Chief Complaints:
1._____
2._____
3._____
4._____

History of Present Illness: Describe any physical or mental illness. _____
_____
_____
_____

Past History

Medical_____
_____
Allergies_____
Frequency of attacks:_____ Severity:_____
Surgical_____
_____
OB/GYN_____

Family History: Positive Familiar Diseases
_____
_____

Review of Systems

Abnormalities in vision or hearing: _____
Cardiovascular:_____
_____
(heart murmurs, arrhythmia) (chest pain, dyspnea-occurs with exertion or rest)
Pulmonary Disease: _____
_____
(COPD, asthma, dyspnea) (oxygen-if used, number of hours per day)
GI or GU abnormalities: _____
Musculoskeletal: _____
Other abnormalities: _____
_____
_____

PHYSICAL

(Check if normal; Describe deviations from normal at bottom of this section

Height_____ Weight_____ Blood Pressure_____
Eyes: Vision w/o glasses: R 20/_____L 20/_____; with glasses: R 20/_____ L 20/_____
Ears_____ Nose_____ Throat_____Neck_____Thyroid_____
Heart_____
(heart murmurs, arrhythmias, cong failure)
Lungs_____
(COPD, asthma, dyspnea)
Breast Exam_____ Abdomen_____
Musculoskeletal_____
(grip, dexterity, gait, ambulation, ROM) (is assistive device used?)
_____
(describe type of arthritis, deformity, paralysis, or limitations)
Peripheral Vascular System _____
(skin ulcerations, pulses, varicose veins)
Skin_____ Genitalia _____
(rectal-pelvis)
Neurologic Exam _____
(motor, sensory, cranial nerves, atrophy or tremor, and reflexes)
Describe all abnormalities or deviations from normal: _____
_____
_____
_____

SUMMARY
Diagnoses 1._____ _____
2._____
3._____

Limitations 1._____ _____
2._____ _____
3._____ _____
(Specify whether permanent or temporary, or likely to be improved wit therapy)

RECOMMENDATIONS

Additional specialty exam _____
Additional diagnostic procedures _____
Restrictions_____

_____ _____ _____
Physician Date of Exam

_____ _____ _____
Address Phone

Please return the completed form to:

If more space is needed, please attach plain sheet to back of this form and sign below the information provided.