

VENTURES IN PEACE PHYSICAL EXAMINATION FORM

Please have form completed by a physician within six months or upon enrollment at Ventures in Peace.

NAME _____ BIRTH DATE _____ DATE OF EXAM _____

Pulse _____ Height _____ Blood Pressure _____ Weight _____

Eyes: Glasses? _____ Vision: R - _____ L - _____ Funduscopy _____

Ears _____ Lymph _____ Genitalia _____

Nose _____ Chest _____ Neurological _____

Throat _____ Heart _____ Musculoskeletal _____

Neck _____ Abdomen _____ Scoliosis _____

Significant findings or recommendations:

Are there any physical impairments that would limit this patient's ability to participate in vigorous physical activities?

Please list all current medical problems that are now under treatment. Include all medications and the dosage.

Which non-prescription medications are NOT appropriate for the patient to take due to the above medications or current health problems?

REQUIRED LABORATORY TESTS AND IMMUNIZATIONS (please attach results)

Urinalysis _____ Hepatitis _____ Pregnancy test: _____

CBC w/differential _____ HIV _____ Chlamydia _____

VDRL _____ Tetanus (within 10 years) Date _____

Fasting Glucose _____ Tuberculosis (skin test within 1 year) Date _____ Results _____

Other _____

Physician's Signature _____

Print Name _____

Address _____

Phone _____ Fax _____

Return completed form to: PO Box 1750 ~ Lolo, MT ~ 59847~ (406) 273-4273 ~ (406) 273-4658 (Fax) ~ www.venturesinpeace.com