TEXAS Department of Assistive and Rehabilitative Services

Division for Rehabilitation Services

General Physical Examination Report

The information requested is necessary to help counselors determine eligibility and/or a plan for rehabilitation services for the person named.

Return Information

Return Report To (Name):		Telephone Number:	
Address:	City:	State:	ZIP Code:

Patient Information

Name:	Date of Birth:
Social Security Number:	Telephone Number:

Reported Disability:

Reason for Referral:

Condensed Medical History

Provide a condensed medical history:

Examination

Please describe any abnormalities:

Height:	Weight:	Pulse:	Blood Pressure:

Vision (Snellen):		With glasses, if available:	
Right 20/	Left 20/	Right 20/	Left 20/

Select normal or abnormal for each item.			
	Normal	**Abnormal**	**Comments**
Pulse	☐	☐	
Blood Pressure	☐	☐	
Head - Scalp	☐	☐	
Eyes	☐	☐	
Ears - Nose - Throat	☐	☐	
Dental - Mouth	☐	☐	
Neck	☐	☐	
Skin	☐	☐	
Chest - Lungs	☐	☐	
Heart - Arteries	☐	☐	
Abdomen	☐	☐	
Hernias	☐	☐	
Bones - Joints	☐	☐	
Muscular	☐	☐	
Neurological	☐	☐	
Genito - Urinary	☐	☐	
Rectal (if indicated)	☐	☐	
Pelvic (if indicated)	☐	☐	
Other:	☐	☐	Specify:

Laboratory

Urine:	Dipstick urinalysis for protein, sugar, and hemoglobin is required, or more complete urinalysis with microscopic if examiner feels it is needed. Results: Select one: ☐ Within normal limits ☐ Abnormal
	If Abnormal, please explain:
Blood:	Physician may do hemoglobin (or hematocrit) and serology, if indicated. Results: Select one: ☐ Within normal limits ☐ Abnormal
	If Abnormal, please explain:

X-Ray

X-Ray:	With this general examination, chest X-rays (AP & lateral) are authorized when physician indicates need. These X-rays should be obtained if evidence of past or present TB exists, or presence of other active pulmonary disease is found during exam. Other X-ray studies require prior authorization for payment by counselor. Fees paid for these procedures may not exceed the DRS fee schedules. Results: Select one: ☐ Within normal limits ☐ Abnormal

	If Abnormal, please explain:

Diagnosis and Impressions

Diagnosis:

Your Opinion: Can the major disability be removed or substantially improved by medical or surgical treatment? ☐ Yes ☐ No

If No, please explain:

Functional Assessment

What can this patient do now? Select one functional level for each activity during an eight-hour workday:	Continuously, 66% or more	Frequently, 33 - 66%	Occasionally, Up to 33%	Not at all
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Lifting 10 lb. or less	☐	☐	☐	☐
Lifting 10 - 20 lb.	☐	☐	☐	☐
Lifting 20 - 50 lb.	☐	☐	☐	☐
Lifting 50 - 100 lb.	☐	☐	☐	☐
Lifting over 100 lb.	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Stooping, kneeling, squatting, and crouching	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Climbing and balancing	☐	☐	☐	☐
Other functional limitation	☐	☐	☐	☐

Describe any other functional limitations:

Working Conditions

Select any working conditions to be avoided:

☐ Indoors	☐ Outdoors	☐ Dusty
☐ High humidity	☐ Marked temperature changes	☐ Dry

☐ Other - Specify:

Remarks and/or Recommendations

Any other remarks or recommendations; for example, other diagnostic examinations:

All information is treated as confidential.
Examinee has the legal right to see this report when the examinee requests.

Examining Physician's Name (type or print):	Telephone Number:

Physician's Address:	City:	State:	ZIP Code:

X _____	_____
Examining Physician's Signature	**Date of Examination**