

HIS CARING PLACE
2401 W CYPRESS CREEK RD
FORT LAUDERDALE, FL. 33309
(954) 429-9222

PHYSICAL EXAMINATION

Name: _____ D/O/B _____

Address: _____ Zip: _____

Phone Number: () _____

Physicians Name: _____

Address: _____ Zip: _____

Phone Number: () _____

**DOCTORS OFFICE: PLEASE SEND COPIES OF ALL LABORATORY BLOOD
WORK AND DOCTORS'S REPORTS TO: FAX NUMBER: (954)977-9774 OR
CALL (954)429-9222 WITH ANY QUESTIONS. ALL REPORTS MUST BE
RECEIVED PRIOR TO ADMISSION.**

Date of exam: _____

Confirmation of pregnancy: Yes ___ No ___

E.D.C.: _____ Height: _____ Weight: _____

Blood Pressure: _____

Current medications needed: _____

(PLEASE CHECK EITHER POSITIVE OR NEGATIVE)

Tuberculin tests:

Date: _____ Positive _____ Negative _____

Hepatitis: Positive _____ Negative _____ Type _____

Positive _____ Negative _____ Type _____
Positive _____ Negative _____ Type _____

HIV testing results: Positive _____ Negative _____

Alcohol and drug screen Positive _____ Negative _____

If positive, what substance? _____

Syphilis: Positive _____ Negative _____

Chlamydia: Positive _____ Negative _____

Candida: Positive _____ Negative _____

Gonorrhoea: Positive _____ Negative _____

Condylomas/HPV Positive _____ Negative _____

Herpes Positive _____ Negative _____

Immunization record: *Please obtain from a family doctor if possible.*

Print Signature

Date

Signature of Physician