

Teen Challenge of Kentucky
P.O. Box 14192
Louisville, KY 40214
Phone: 502-561-2131 Fax: 502-561-2132

Health Screening Form
TO BE COMPLETED BY PHYSICIAN ONLY

General Information

Today's Date _____

1. Name _____ D.O.B. _____

2. Present Illness/Complaint/Disabilities, if any: _____

3. Allergies: _____

4. Medicine currently prescribed and reason: _____

5. Has client been exposed to any communicable diseases? Yes _____ No _____

If yes, please specify: _____

6. History of chronic or major illness: _____

7. Operations: _____

8. Hospitalizations: _____

9. Immunizations: Last Tetanus Toxoid _____ Polio _____ Measles _____

Mumps _____ Rubella _____ Other _____

Physical Examination

Code: Satisfactory = S Unsatisfactory = U Not Examined = O

Height _____ Weight _____ B/P _____

Pulse _____ Respirations _____ Temperature _____

General Appearance (including skymata of drug use) _____

Head (check for head lice) _____

Ears _____ Hearing: R _____ L _____ Eyes _____

Vision: (without glasses) R _____ L _____ (with glasses) R _____ L _____

Nose _____ Throat _____ Mouth/Teeth _____ Neck/Thyroid _____ Chest _____

Cardiac _____ Abdomen _____ Genitalia _____ Hernia _____ Skin _____

Musculo-Skeletal _____ Body Lice _____ Scabies _____ Neurologic _____

Required Tests

VDRL _____ *TB _____ Pregnancy _____

Hepatitis Screening:(not shots) Urinalysis _____ Pap Smear _____

A _____ Dental Exam _____ HIV _____

B _____ Liver Function _____ CBC _____

C _____

*TB results must be within 30 days of entry

Attach computer printout of all test results

General comments, assessments, and recommendations on above: _____

Signature of Examining Physician: _____

Address

Phone