

**OKLAHOMA DEPARTMENT OF CORRECTIONS
INITIAL INTAKE & ROUTINE PHYSICAL EXAMINATION**

(4-4365 b- 6, 10, 11, 4-4366 b-1)

DOB	Age	Race	Sex	HT	WT	Pulse	Resp	Temp	B/P	Drug/Food Allergies:
(4-4365M b-4, 4-4366 b-2)										

HEARING (Conversational) <i>Please Check Appropriate Box(s):</i>					VISION (Distant)	
Right Ear	Normal	Mild Loss	Moderate Loss	Deaf	Corrected	Uncorrected
Left Ear	Normal	Mild Loss	Moderate Loss	Deaf	OD 20/_____	OS 20/_____

PHYSICAL FINDINGS <small>(4-4365M b-2)</small>	WNL	ABN	DESCRIPTION OF ABNORMAL FINDINGS <i>(List by Number)</i> <small>(4-4365M b- 8, 9, 12, 4-4366 b-3,4,5)</small>
1. Skin			
2. Lymph Nodes			
3. Head, Scalp			
4. Neck, Face			
5. Eyes			
6. Ears			
7. Nose			
8. Throat, Mouth, Teeth			
9. Chest, Lungs			
10. Heart			
11. Peripheral pulses			
12. Abdomen			
13. Genitourinary			
14. Back			
a. Forwarding bending			
b. Side-bending			
c. Squat			
d. Heel walking (L4-L5)			
e. Toe walking (L5-S1)			
f. Straight leg raise			
15. Upper extremities			
16. Lower extremities			
17. Neurologic			
18. Prostate, Rectal			
19. Pelvic			
20. Breast			
21. Mental Status			
22. Other			

PAST MEDICAL HISTORY <small>(4-4366 b-2)</small> To facilitate placement for classification define illness(es) as mild, moderate or severe	Assessment
1. Significant Illness(es)	
2. Significant Injuries	
3. Recent Hospitalizations (Within last 5 years)	
4. Surgical Procedures	
5. Other:	

Facility Name: _____ Date: _____

Provider's Signature: _____ Provider's Name: _____

Inmate Name: _____ DOC #: _____
(Last, First)

OKLAHOMA DEPARTMENT OF CORRECTIONS
Periodic Personal Health History
(4-4366 b-2)

Date: _____

Please complete the following questions as accurately as possible. This information concerns **new** health events since your last physical examination and is **confidential**.

1. **Allergies**

- A. Medication (list) _____

- B. Food (list) _____

- C. Other (list) _____

2. **Current Medications**

Are you current on any medications: Yes No If "Yes" list the medications: _____

3. **Current Medical Problems**

Have there been any medical problems since your last physical? Yes No If "Yes" describe: _____

4. **Family History**

Have you had any new family history: (check as applicable)

- | | |
|--|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Clots (VTE) |

5. **Obstetrical/Gynecological History (Women's Health)**

Date of last menstrual period: _____ Number of days: _____ Was the flow normal? Yes No
Was it normal? Yes No If "No" describe: _____

6. Are there any other health concerns that you wish to mention? Yes No If "Yes" describe: _____

7. **Emergency Contact:**

Name: _____ Home Phone: _____ Work Phone: _____
Name: _____ Home Phone: _____ Work Phone: _____

Inmate Name
(Last, First)

DOC Number