

OKLAHOMA DEPARTMENT OF CORRECTIONS
INITIAL INTAKE and ROUTINE PHYSICAL EXAMINATION

(5-ACI-6A-25M b#1, b#2, b#3, b#4, b#5, b#6, b#7, b#10)

DOB	Age	Race	Sex	HT	WT	Pulse	Resp	Temp	B/P	Drug/Food Allergies:
(5-ACI-6A-25M b#3)										

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 (5-ACI-6A-25M b#5)	WNL	ABN	DESCRIPTION OF ABNORMAL FINDINGS <i>(List by Number)</i> (5-ACI-6A-25M b#8, b#9, b#10)	
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				Assessment
16. Lower extremities				
17. Neurologic				
18. Prostate, Rectal				
19. Pelvic				
20. Breast				
21. Mental Status				
22. Other				
PAST MEDICAL HISTORY To facilitate placement for classification define illness(es) as mild, moderate or severe				
1. Significant Illness/illnesses				
2. Significant Injuries				
3. Recent Hospitalizations (within last five years)				
4. Surgical Procedures				
5. Other:				

Facility Name: _____ Date: _____

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

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

OKLAHOMA DEPARTMENT OF CORRECTIONS
Periodic Personal Health History

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)

ODOC Number