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

PHYSICAL FINDINGS (5-ACI-6A-25M b#5)	WNL	ABN	DESCRIPTION OF ABNORMAL FINDINGS *(List by Number)* (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			
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	Assessment
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: (Last, First) ODOC #:

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)

   ☐ Breast Cancer ☐ Heart Disease
   ☐ Prostate Cancer ☐ Diabetes
   ☐ Colon Cancer ☐ High Blood Pressure
   ☐ Stroke ☐ 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