STATE OF CALIFORNIA DEPARTMENT OF REHABILITATION

REPORT OF GENERAL MEDICAL EXAMINATION

DR 223 (Rev. 09/01)

Please note when you release your patient's medical information and it makes reference to the results of any HIV test performed State law requires that you have a specific release of information from your patient.

Under State law and departmental regulations, all information that you supply to the Department of Rehabilitation is maintained in files that are subject to inspection by the enclosed named applicant/client.

Please send completed report to:
Department of Rehabilitation

Counselor's Name:

THIS REPORT IS TO BE USED PRIMARILY FOR DETERMINING MEDICAL ELIGIBILITY

Patient's Name (First, MI,	Last)	Birthdate	Sex	Marital Status	S	M	W	Sep	Race
			M☐F☐		☐	☐	☐	☐	

Address (Street and Number)	City	State

NOTE:
Please see that the original of this form is completed on both sides and returned to the Department of Rehabilitation.

Family Physician:
Name:
Address:
Telephone:

Nature of Major Disability in the Applicant's own words:

SIGNIFICANT MEDICAL HISTORY: e.g., Major physical and mental illness, accidents, operations, alcoholism, drug abuse, learning disability, mental retardation, etc. Report recent x-rays and lab work.

Present Medication and Response:

Other Treating Physicians (Names, Addresses and Nature of Treatment):

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General Appearance and Mental Attitude:

WEIGHT:	HEIGHT:	GAIT:	HEARING:
_____ lbs.	___ ft ____ in.		Right 20/____ Left 20/____

VISION:

Distance Visual Acuity:
Without Glasses:
Right 20/____ Left 20/____
With Glasses:
Right 20/____ Left 20/____

Near Visual Acuity:
Without Glasses:
Right 20/____ Left 20/____
With Glasses:
Right 20/____ Left 20/____

Jaeger:
Right J-____ Left J-____

BLOOD PRESSURE	PULSE RATE	DYSPNEA	CYANOSIS	EDEMA

Please indicate positive findings in below mentioned structures with a "P". If findings are positive, please describe briefly under 'COMMENTS AND FINDINGS':

_____ Eyes	_____ Lungs	_____ Skin
_____ Ears	_____ Heart	_____ Musculoskeletal
_____ Nose	_____ Blood vessels	_____ Nervous System
_____ Mouth	_____ Breasts	_____ Varicosities
_____ Throat	_____ Abdomen	_____ Anorectal
_____ Neck	_____ Hernia	_____ Rectal Exam (if indicated)
_____ Lymph Nodes	_____ G. U.	_____ Pelvic Exam (if indicated)

URINALYSIS: 1) Gross Exam 2) Sugar 3) Albumin 4) Other

COMMENTS AND FINDINGS: *(Include dental)*

DISABILITY IS:

- ☐ **Stable**
- ☐ **Progressive**
- ☐ **Resolving**

DIAGNOSTIC IMPRESSION:

RECOMMENDATIONS, REMARKS AND PROGNOSIS: *(Please provide prescription for recommended locomotor and self-care aids, prosthetic - orthotic devices, wheelchair, etc. Indicate additional diagnostic studies needed.)*

Please check only those physical activities and work conditions which are contra-indicated during a work day period:

Physical Activities

1. ____ Walking
2. ____ Jumping
3. ____ Running
4. ____ Balancing
5. ____ Climbing
6. ____ Crawling
7. ____ Standing
8. ____ Turning
9. ____ Stooping
10. ____ Crouching
11. ____ Kneeling
12. ____ Sitting
13. ____ Reaching
14. ____ Lifting
15. ____ Carrying
16. ____ Throwing
17. ____ Pushing
18. ____ Pulling
19. ____ Handling
20. ____ Fingering
21. ____ Feeling
22. ____ Talking
23. ____ Hearing
24. ____ Seeing
25. ____ Color vision
26. ____ Depth perception

Working Conditions

27. ____ Inside
28. ____ Outside
29. ____ Hot
30. ____ Cold
31. ____ Dusty
32. ____ Wet
33. ____ Humid
34. ____ Dry
35. ____ Sudden temp. change
36. ____ Dirty
37. ____ Odors
38. ____ Noisy
39. ____ Limited light
40. ____ Vibration
41. ____ Moving objects
42. ____ Cramped quarters
43. ____ High places
44. ____ Working w/others
45. ____ Working alone
46. ____ Mechanical

Client will be able to participate in: ☐ Full time Work ☐ Part Time Work ☐ Selective Retraining ☐ No Work

Date of Examination	Physician's Name *(Please print or type)*
Physician's License Number	Physician's Signature ✍