

**STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES - DIVISION OF DEVELOPMENTAL DISABILITIES**

**Medical Form for Adults**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ { } Male { } Female  
 Health Insurance #: \_\_\_\_\_ SS#: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**A. HISTORY:**

- 1) Indicate any present and past medical condition (include communicable disease history):  
 \_\_\_\_\_  
 \_\_\_\_\_
- 2) Previous hospitalizations/surgery: \_\_\_\_\_  
 \_\_\_\_\_
- 3) Immunizations:  
 Adult Diphtheria/Tetanus-Date: \_\_\_\_\_  
 (Document date of last booster OR administer if more than 10 years ago.)  
 Hepatitis B Immunization (if given) Date: [1] \_\_\_\_\_ [2] \_\_\_\_\_ [3] \_\_\_\_\_

**B. LABORATORY TESTS:**

- 1) **Mantoux Test yearly** if non-reactor or chest x-ray if indicated. Past or current results must be documented:  
 Results: \_\_\_\_\_ Date: \_\_\_\_\_  
 Tine test is not acceptable. Positive Mantoux reactor should never be retested.
- 2) Hepatitis B Profile: Initial (repeat at physician's discretion).  
 Results: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Past or current results must be documented).
- 3) Lead Poisoning: Blood Lead Level is required:
  - a. For Individuals with known Pica behavior, test annually, or according to guidelines for elevated lead levels
  - b. Prior to discharge from development center (within 3 months of discharge).
  - c. For all new admissions to Divisional residential services (within 3 months prior to admission or within 10 days after admission).  
 Blood Level: \_\_\_\_\_ Date: \_\_\_\_\_
- 4) SMAC, initial (repeat at physician's discretion): \_\_\_\_\_
- 5) Complete Blood Count, initial (repeat at physician's discretion): \_\_\_\_\_
- 6) Urinalysis, initial (repeat at physician's discretion): \_\_\_\_\_
- 7) Serology, initial (repeat at physician's discretion): \_\_\_\_\_
- 8) Pap Smear (follow American Cancer Society guidelines): \_\_\_\_\_
- 9) EKG – initial at age 40 (repeat at physician's discretion): \_\_\_\_\_

**C. OTHER MEDICAL CONDITIONS/NEEDS:**

- 1) Seizures: { } Yes { } No Frequency & Type, if known: \_\_\_\_\_  
 \_\_\_\_\_
- 2) Special Dietary Needs: { } Yes { } No (Attach Prescription): \_\_\_\_\_  
 \_\_\_\_\_
- 3) Allergies, Sensitivities: (foods, drugs, others): \_\_\_\_\_  
 \_\_\_\_\_
- 4) Mental Health Problems (Behavioral/Psychiatric Disorders): \_\_\_\_\_  
 \_\_\_\_\_

**D. MEDICATION:**

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Indication: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Indication: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Indication: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Indication: \_\_\_\_\_  
 Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Indication: \_\_\_\_\_

**E. CLINICAL EXAMINATION:**

- 1) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp.: \_\_\_\_\_ Pulse: \_\_\_\_\_ B.P.: \_\_\_\_\_
- 2) Sensory (Indicate any impairment and extent):  
 Eyes: Vision (Glasses, etc.): \_\_\_\_\_  
 Hearing: (Aids, etc.): \_\_\_\_\_
- 3) ENT: \_\_\_\_\_
- 4) Teeth & Gums: \_\_\_\_\_
- 5) Neck: \_\_\_\_\_
- 6) Breast (Follow American Cancer Society Guidelines for Mammography): \_\_\_\_\_  
 \_\_\_\_\_
- 7) Lymphatic System: \_\_\_\_\_
- 8) Respiratory System: \_\_\_\_\_
- 9) Cardiovascular System: \_\_\_\_\_
- 10) Gastrointestinal System (Stool for occult blood after age 50): \_\_\_\_\_
- 11) Genitourinary System: \_\_\_\_\_
- 12) Prostate: \_\_\_\_\_
- 13) Muscular System: \_\_\_\_\_
- 14) Skeletal System: \_\_\_\_\_
- 15) Neurological System: \_\_\_\_\_

**ADDITIONAL INFORMATION/RECOMMENDATIONS:**

(Please indicate if there are limitations or restrictions regarding physical activities)

\_\_\_\_\_  
 \_\_\_\_\_

**PLEASE ISSUE PRESCRIPTIONS FOR MEDICATION, DIET, ADAPTIVE EQUIPMENT, PROCEDURES AND THERAPIES. (Please Print or Type CLEARLY)**

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

**PLEASE RETURN COMPLETED FORM TO:**

NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION**