



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department on Disability Services
Developmental Disability Administration

MEDICAL EVALUATION FORM

Please complete this *official* document, it that will be kept on file. Do not leave a section blank, use N/A (not-assessed or not-applicable) as appropriate.

Name: _____	Date of Evaluation: _____
DOB: _____	Accompanied by: _____
SSN: _____	Guardian: _____

Please check **only** those items that are attributed to the cause of, or have an association to the diagnosis of an intellectual/developmental disability.

<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Rubella
<input type="checkbox"/> Fragile X	<input type="checkbox"/> Other Infection
<input type="checkbox"/> Edward's Syndrome	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Prader Willi	<input type="checkbox"/> Autism
<input type="checkbox"/> Other genetic Syndrome	<input type="checkbox"/> Debrile Illness-infancy
<input type="checkbox"/> Fetal Alcohol Syndrome	<input type="checkbox"/> Other/Unknown _____
<input type="checkbox"/> Head Injury	

Known Medical and Psychiatric Diagnoses:

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Medications:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____





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Allergies (Drug or Food): _____ None _____

Chest X-Ray or PPD (Circle): Result(s) _____ Date _____

Mammogram/Sonogram/Theragram results _____ Date _____

Vaccinated Against Hepatitis B: Yes _____ No _____ Date _____

Developmental History (Include when disability was first noted):

Current Complaints and History of Present Illness (es):

Significant Past Medical History (include hospitalizations and surgeries):

Habits (amount and frequency): Denied _____ Tobacco _____ Alcohol _____

Substance Abuse: Denied _____ Cocaine _____ Heroin _____ PCP _____
Marijuana _____ Other _____

Social History

Sexual History

Environmental Concerns Relevant to Health





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PHYSICAL EXAM:

Height _____ Blood Pressure _____ Temperature _____

Weight _____ Pulse _____ Respiratory Rate _____

General Appearance/Anomalies _____

Head, Eyes, Neck _____

Ear, Nose, Mouth, Throat _____

Chest Wall/Breasts _____

Cardiovascular: Heart _____ Peripheral _____

Abdomen (including scars) _____

Genitourinary (as applicable):

FEMALE

Vulva Vagina, Uterus _____

Anorectal: External _____ Vault _____ Stool guaiac _____

Pap Smear: Done: Yes _____ Results _____ No _____ Date _____

MALE

Penis, scrotum, testes _____

Anorectal: External _____ Vault _____ Stool guaiac _____

Prostate: Done: Yes _____ Results _____ No _____ Date _____

Skin and Nails: _____

Extremities: _____

Lymphatics: _____

Neurological (include cranial nerves, balance and strength):





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Lab results (copy of complete report to be attached):

- | | | | |
|---------|-------|----------------|-------|
| 1. CBC | _____ | 5. HbsAg | _____ |
| 2. CMP | _____ | 6. Cholesterol | _____ |
| 3. U/A | _____ | 7. Other | _____ |
| 4. VDRL | _____ | | _____ |

Diagnoses(s):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Specific Recommendation and Plans:

1. _____
2. _____
3. _____
4. _____

Recommended Clinical Services:

- Occupational Therapy
- Physical Therapy
- Speech and Language
- Nutrition
- Skilled Nursing
- Fitness Training
- Massage Therapy
- Labs: _____
- Other _____

(Print) Medical Provider's Name

Signature

Date

Address: _____

Telephone: _____

Fax: _____

