DMA -5006 (Rev. 10/91)

(DSS - 1653)

STATE OF NORTH CAROLINA

DEPARTMENT OF HUMAN RESOURCES

REPORT OF MEDICAL EXAMINATION REQUESTED BY
_____ COUNTY DEPARTMENT OF SOCIAL SERVICES

Part I. (To be filled in by county DSS) Case No._____

Name of patient _____ Dist No. _____

Address _____

Age or birthdate _____ / SSN_____

_____ _____
Date Director of Social Services

Part II. (For Applicant, Recipient, Personal Representative or Guardian)

I hereby authorize any physician, hospital, or clinic who has treated or examined me to give the county Department of Social Services and the Disability Determination Section, Department of Human Resources, information about my present or past condition of health.

_____ _____
Date Signature of Applicant, Recipient, Personal Representative or Guardian

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Part III. (Medical Report) Note to physicians/psychologists: Please complete this form giving sufficient details to enable a reviewing physician to make an independent determination as to the severity and duration of the impairments. This form is provided for your convenience. The substitution of a narrative report is acceptable. In addition, copies of office notes, hospital discharge summaries and especially, reports of laboratory studies, x-rays and other objective studies for at least the previous 12 months are needed. A signed consent for release of information is attached.

A. Complaint (In patient's own words) _____
_____
_____
Date of Onset _____ Date of First Examined _____
Frequency of Visits _____ Date of Most Recent Examination _____
History _____

B. Findings on Examination:
General Appearance _____ Posture _____ Gait _____
Height _____ Weight _____
Cardio-Vascular System:
(1) Blood Pressure ___(Systolic)_____ Pulse Rate _____ Rhythm _____
(Diastolic)
(2) Heart: Size _____ Sounds _____
(3) Edema _____
(4) Dyspnea _____ ( ) At rest ( ) On slight exertion ( ) On moderate exertion
(5) Angina _____ ( ) At rest ( ) On slight exertion ( ) On moderate exertion
(6) Functional capacity (American Heart Assn.) Class I _____ II _____ III _____ IV _____
(7) Report of ECG: _____ Date _____
(8) Degree of Arteriosclerosis, if present: _____

Figure 3

Is there any abnormality of the following:	Yes	No	Describe Any Abnormal Findings
1. Eyes			
2. Ears			
3. Nose, Throat, Mouth			
4. Breasts			
5. Lungs			
6. Abdomen			
7. Hernia			
8. Varicose Veins			
9. Skin			
10. Genitro-Urinary			
11. Gynecological			
12. Ano-Rectal			
13. Endocrine System			
14. Lymphatic System			
15. Bones, Joints, Muscles			
16. Nervous System			
17. Mental Status			
18. Blood, as Anemia, Leukemia			
19. Other			

D. LABORATORY AND SPECIAL STUDIES: Give results of all pertinent studies with dates.

_____

_____

E. Diagnosis: 1. Major impairments: _____
2. Minor impairments: _____

F. Do you believe further diagnostic examination is indicated? _____
If "Yes", describe in detail _____

_____

G. Is there evidence of any impairment not covered above? (Describe) _____

_____

H. What restrictions on activities are imposed by impairment? _____

_____

I. Is any treatment (medical or surgical) recommended to correct or improve major impairment?

_____

J. Prognosis and remarks: _____

K. Work capacity: ( ) Full Time ( ) Part Time ( ) None
Should work be restricted as to: Type _____ Hours per Day _____

Estimated period individual will be unable to return to work: _____

Reporting Physician's Name and Address (Please Type or Print)	Signature of Physician	Degree
	Telephone No	Date of this report