

## PHYSICAL EXAMINATION REPORT FORM

Patient Name- Last		First		Middle		Date of Birth		Sex		Social Security	
Height	Weight	B.P.	Temperature	Pulse	Respiration	<b>URINALYSIS</b>					
						S.G.	Sugar	Protein	Other	U.D.S.	
Vision Glasses ♂      Contacts ♂		Distance R 20/      CORR 20/ L 20/      CORR 20/		Near R 20/      CORR 20/ L 20/      CORR 20/		Color		Depth		Peripheral	
Chest X-Ray		(AP & LAT)		EKG		Treadmill N/A		Spirometry		T.B. Skin Test      Audio	
<b>BLOOD PROFILE</b>								Physician's Signature		Date	
CBC		SMA		Serology N/A		Blood Type & RH					
Recommendations											
NORMAL	ABNORMAL						<b>DESCRIBE EACH ABNORMALITY IN DETAIL</b>				
		1 General Appearance									
		2 Head and Neck									
		3 Scalp and Face									
		4 Eyes (Describe Fundoscopic if Abnormal)									
		5 Pupils, Ocular Moility									
		6 Nose and Sinuses									
		7 Mouth and Throat									
		8 Teeth									
		9 Ears, Tympanic Membrane									
		1 Thyroid									
		11 Thorax (Includes Breasts if examined)									
		12 Lungs									
		13 Heart									
		14 Peripheral Vascular System									
		15 Abdomen									
		16 Hernia									
		17 Anus (Describe Rectal if examined)									
		18 Genitalia									
		19 Spine (Mobility, Abnormal)									
		20 Upper Extremities									
		21 Lower Extremities									
		22 Feet (Pes Planus Talipes, etc.)									
		23 Skin									
		24 Lymphatic									
		25 Endocrine									
		26 Neuromuscular									
		27 Psychiatric (Mental Attitude)									
		28 Scars, Tattoos, Marks									
NO	YES	29 Pelvic (if examined)									
Physician's Name: _____						Address: _____					
Physician's Telephone No: _____						City & State: _____					