

General Physical Examination Checklist

Name: _____

Date of birth: _____

Patient identifier: _____

Date of examination: _____

Temperature: _____

Heart rate: _____

Respiratory rate: _____

Blood pressure: _____

SPO2: _____

Are the following normal without abnormal features? If abnormal, please describe below.

General appearance and vitals	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Ear, nose, throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:

Cardiovascular	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Vascular	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Lungs and chest	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Abdomen and viscera (including hernia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Lymphatic (spleen/lymph nodes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Back/spine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Extremities/joints	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Endocrine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:

Genito-urinary	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Locomotor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Neurological system (including reflexes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Gait	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:
Urinalysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not examined	Comments:

Additional notes