

Medical Examination Report

Patient Information						
First Name	Last Name	Date of Birth	Examination Date			
Medical History						
Medical Conditions and History						
Current Medications						
Radiology						
Images Taken						
Summary of Radiological Findings						
Testing						
Height	Weight	Pulse Rate	Pulse Rhythm Regularity			
Systolic BP (Seated)	Diastolic BP (Seated)	Systolic BP (Second Reading)	Diastolic BP (Second Reading)			
Vision	Unaided			Aided		
	Right Eye	Left Eye	Binocular	Right Eye	Left Eye	Binocular
Distant						
Near						
Other Vision Test Results						

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Testing (Continued)			
Hearing Aids <input type="checkbox"/> No <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both		Audiometric Test Results	
Lab Results			
Notes			
Physical Examination			
Are the following normal without unusual features?			
General <input type="checkbox"/> Yes <input type="checkbox"/> No	Ears, Nose, Throat (ENT) <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech <input type="checkbox"/> Yes <input type="checkbox"/> No
Audiogram Normal <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular System <input type="checkbox"/> Yes <input type="checkbox"/> No	Lungs and Chest <input type="checkbox"/> Yes <input type="checkbox"/> No
Abdomen and Viscera (Including Hernia) <input type="checkbox"/> Yes <input type="checkbox"/> No	Lymphatic System (Spleen/Lymph Nodes) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Back/Spine <input type="checkbox"/> Yes <input type="checkbox"/> No	Extremities/Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	Genito-urinary <input type="checkbox"/> Yes <input type="checkbox"/> No
Skin <input type="checkbox"/> Yes <input type="checkbox"/> No	Locomotor <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological System (Including Reflexes) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gait <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No	Urinalysis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Notes			
Name of Examining Doctor (Printed)	Signature	Date	