

# Normal Physical Exam

First Name	Last Name	Date of Birth	Patient Identifier	Date of Examination
Temperature	Heart Rate	Respiratory Rate	Blood Pressure	SPO2
<b>Are the following normal without abnormal features? If abnormal, please describe below</b>				
<b>General Appearance &amp; Vitals</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Ear, Nose, Throat</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Mouth</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Speech</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Cardiovascular</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Vascular</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Lungs and Chest</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Abdomen and Viscera</b> (including Hernia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Lymphatic</b> (Spleen/Lymph Nodes) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				

Normal Physical Exam (Page 2)				
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<b>Are the following normal without abnormal features? If abnormal, please describe below</b>				
<b>Back/Spine</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Extremities/Joints</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Endocrine</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Genito-urinary</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Skin</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Locomotor</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Neurological System</b> (including reflexes) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Gait</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Psychiatric</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
<b>Urinalysis</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				

### Normal Physical Exam (Page 3)

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### Notes

Clinician Name	Clinician Designation	Clinician Signature	Date
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