

Physical Exam Checklist

Date: _____

Patient's Name: _____

Date of Birth: _____

Gender: _____

Contact Information: _____

Referring Physician's Name: _____

Contact Information: _____

Chief Complaint:

Medical History:

PHYSICAL EXAM CHECKLIST

| | | | |
|---|---|--|--|
| <input type="checkbox"/> General Appearance | <input type="checkbox"/> Vitals | <input type="checkbox"/> Ear, Nose, Throat | <input type="checkbox"/> Mouth |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Musculoskeletal |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Dermatological | <input type="checkbox"/> Lymphatic |
| <input type="checkbox"/> Back/Spine | <input type="checkbox"/> Extremities/Joints | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Genitourinary |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Locomotor | <input type="checkbox"/> Gait | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Urinalysis | | | |

Notes: