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

☐ General Appearance	☐ Vitals	☐ Ear, Nose, Throat	☐ Mouth
☐ Speech	☐ Cardiovascular	☐ Respiratory	☐ Musculoskeletal
☐ Neurological	☐ Gastrointestinal	☐ Dermatological	☐ Lymphatic
☐ Back/Spine	☐ Extremities/Joints	☐ Endocrine	☐ Genitourinary
☐ Skin	☐ Locomotor	☐ Gait	☐ Psychiatric
☐ Urinalysis			

Notes: