

# Physical Exam

Basic Information				
First Name	Last Name	Date of Birth	Patient Identifier	Date of Examination
Physical Examination				
Are the following normal without abnormal features? If abnormal, please describe below				
<b>General Appearance</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				

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Physical Examination (Continued)			
<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			

**Basic Information**

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**Notes**

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Clinician Name	Clinician Designation	Clinician Signature	Date
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