

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				
General Appearance <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Ear, Nose, Throat <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Mouth <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Speech <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Cardiovascular <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Vascular <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Lungs and Chest <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Abdomen and Viscera (including Hernia) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				
Lymphatic (Spleen/Lymph Nodes) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined				

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Physical Examination (Continued)			
Back/Spine <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Extremities/Joints <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Endocrine <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Genito-urinary <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Skin <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Locomotor <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Neurological System (including reflexes) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Gait <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Psychiatric <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			
Urinalysis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Examined			

Basic Information

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Clinician Name	Clinician Designation	Clinician Signature	Date
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