PHYSICAL EXAM FORM

THIS FORM MUST BE COMPLETED BY AN M.D., D.O., NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT AND PATIENT MUST PRESENT A VALID GOVERNMENT ID WITH SIGNATURE.

(PLEASE PRINT)

Date____________________ Patient name____

Age _______ Date of Birth ___________________ Height__________ Weight ____________

Blood Pressure____________________ Pulse_________________ Temp________________

Current Medications: ____

Allergies: ____

Medical & Surgical Hx: ____

Review of Systems (please document any abnormalities): _________________________________

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PHYSICAL EXAM		
HEENT:	NORMAL	ABNORMAL:
Cardiovascular:	NORMAL	ABNORMAL:
Respiratory:	NORMAL	ABNORMAL:
Gastrointestinal:	NORMAL	ABNORMAL:
Musculoskeletal:	NORMAL	ABNORMAL:
Skin:	NORMAL	ABNORMAL:
Neurological:	NORMAL	ABNORMAL:
Genitourinary:	NORMAL	ABNORMAL:

Practitioners Signature____

Practitioners Name & Designation ____

Practitioners Address____

Practitioners Phone____

STAMP HERE	I (patient) acknowledge that I ______________________________ have been examined by the practitioner indicated above.