

REPORT OF PHYSICAL EXAMINATION

Birth Date _____

EXAMINATION

Respiration _____ Visions: Snellen R. _____ L. _____ Glasses/Contacts Yes _____ No _____

Any disorders of the following areas?	Yes	No	If Yes, please explain (include current treatments, medications and recommendations)
Head, Neck, Face & Scalp			
Lymph Nodes			
Eyes			
Ears – drums			
Nose – sinuses			
Mouth			
Throat			
Teeth			
Chest and Lungs			
Heart			
Abdomen & Viscera (including hernia)			

Any disorders of the following areas?	Yes	No	If Yes, please explain (include current treatments, medications and recommendations)
Vascular System			
Ano-Rectal			
Genitalia/Reproductive System			
Extremities			
Spine			
Other Musculoskeletal			
Skin			
Neurologic			
Psychiatric/Mental Illness			
Infectious Disease			
Immune Deficiency			
Other			

SUMMARY OF EVALUATION AND REMARKS

List severe illnesses, injuries, or surgeries and date:

List known allergies:

Additional Comments:

Clinician Signature	Date	Address
Print Name	Title	Phone