Medical Examination Report

Patient information	
Name:	**Date of birth:**
Gender:	**Date of examination:**
Address:	
Contact number:	**Email:**

Medical history

Medications			
Name	**Dosage**	**Frequency**	**Remarks**

Vital signs		
Height:	**Weight:**	**Respiratory rate:**

Blood pressure:	**Heart rate:**
Pulse rate:	**Pulse rhythm regularity:**
Systolic BP (seated):	**Diastolic BP (seated):**
Systolic BP (second reading):	**Diastolic BP (second reading):**

Vision						
	Unaided			Aided		
	Right eye	Left eye	Binocular	Right eye	Left eye	Binocular
Distant						
Near						
Other vision test results						

Hearing
Hearing aids: ◯ No ◯ Left ◯ Right ◯ Both
Audiometric test results:

Physical examination			
Are the following normal without unusual features?			
General ◯ Yes ◯ No	Ears, nose, throat (ENT) ◯ Yes ◯ No	Mouth ◯ Yes ◯ No	Speech ◯ Yes ◯ No
Audiogram ◯ Yes ◯ No	Cardiovascular ◯ Yes ◯ No	Vascular system ◯ Yes ◯ No	Lungs and chest ◯ Yes ◯ No
Abdomen and viscera (including hernia) ◯ Yes ◯ No		Lymphatic system (spleen/lymph nodes) ◯ Yes ◯ No	
Back/spine ◯ Yes ◯ No	Extremities/joints ◯ Yes ◯ No	Endocrine ◯ Yes ◯ No	Genito-urinary ◯ Yes ◯ No
Skin ◯ Yes ◯ No	Locomotor ◯ Yes ◯ No	Neurological system (including reflexes) ◯ Yes ◯ No	
Gait ◯ Yes ◯ No	Psychiatric ◯ Yes ◯ No	Urinalysis ◯ Yes ◯ No	

Laboratory tests	
Test name	**Result**
Imaging studies	
Study type	**Findings**
Notes	
Healthcare provider information	
Name:	**License number:**
Signature:	**Date:**