## **Physical Exam Checklist**

Date:

Patient information					
Name:		Gender:			
Date of birth:		Age:			
Medical history:		Medications or supplements currently taken (if applicable):			
Vaccinations received (if applicable):		Symptoms (if applicable):			
Routine check up Acute visit Other:					
If acute visit, quickly assess for urgent care needs. If stable, proceed.					
Airway/breathing Circulation Uncons		cious/convulsing	Pain	Fever	
Health area	Recommended screenings/check-ups	Completed	Notes/remarks		
	Alertness				
	Hydration				
	Weight				
General appearance	Height				
	Body mass index				
	Jaundice, anaemia, cyanosis, clubbing, oedema, and lymphadenopathy (JACCOL)				
	Skin rashes/lesions				
	Others:				

Health area	Recommended screenings/check-ups	Completed	Notes/remarks			
Vital signs	Respiratory rate					
	Heart rate					
	Blood pressure					
	Temperature					
	Oxygen saturation					
	Others:					
Systemic examination	Head, eyes, ears, nose, and throat (HEENT)					
	Cardiovascular					
	Pulmonary					
	Gastrointestinal					
	Genito-urinary					
	Musculoskeletal					
	Skin/dermatological					
	Neurological					
	Others:					
Additional notes						
Physician's name:		Signature:				
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