Physical Exam

Patient information	
Name:	
Date of birth:	**Date of assessment:**
Vital signs	
Blood pressure: mmHg	**Heart rate:** bpm
Respiratory rate: breaths per minute	**Temperature:** ◯ °C ◯ °F
Oxygen saturation (SpO2): %	**Weight:**
Height:	**Body mass index (BMI):**
Physical examination	
Are the following normal without abnormal features? If abnormal, please describe below:	
General appearance: ◯ Yes ◯ No ◯ Not examined	
Ear, nose, throat: ◯ Yes ◯ No ◯ Not examined	
Mouth: ◯ Yes ◯ No ◯ Not examined	
Speech: ◯ Yes ◯ No ◯ Not examined	
Cardiovascular: ◯ Yes ◯ No ◯ Not examined	
Vascular: ◯ Yes ◯ No ◯ Not examined	

Are the following normal without abnormal features? If abnormal, please describe below:	
Lungs and chest: ◯ Yes ◯ No ◯ Not examined	
Abdomen and viscera: (including bowel sounds and hernia) ◯ Yes ◯ No ◯ Not examined	
Lymphatic: (spleen/lymph nodes) ◯ Yes ◯ No ◯ Not examined	
Back/spine: ◯ Yes ◯ No ◯ Not examined	
Extremities/joints: ◯ Yes ◯ No ◯ Not examined	
Endocrine: ◯ Yes ◯ No ◯ Not examined	
Genitourinary: ◯ Yes ◯ No ◯ Not examined	
Skin: ◯ Yes ◯ No ◯ Not examined	
Locomotor: ◯ Yes ◯ No ◯ Not examined	
Neurological system: (cranial nerve responses, reflexes) ◯ Yes ◯ No ◯ Not examined	

Are the following normal without abnormal features? If abnormal, please describe below:	
Gait: ◯ Yes ◯ No ◯ Not examined	
Psychiatric: ◯ Yes ◯ No ◯ Not examined	
Additional notes	
Physician name:	
License number:	**Signature:**
Date:	