



Physical Exam Form

Name:						Date:		
Vital Signs:	Ht	Wt	T°	BP	P	R		
General Appearance:								
Skin:								
HEENT: Head								
Eyes/Vision Screen								
Ears/Hearing Screen								
Mouth/Throat								
Neck:								
Chest:								
Breast:								
Heart:								
Lungs:								
Abdomen:								
Genitalia: GYN/Testicular Exam								
Rectum:								
Musculoskeletal: Back/Spine								
Extremities								
Lymph Nodes:								
Circulatory:								
Neurologic:								
Other:								

HC Provider Signature: _____

Date: _____

Official Office Stamp: