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:	