Physical Form

Date of Physical: _____

Name of Patient:_____ Date of Birth: _____

Height: _____ Weight: _____ BP: _____ Pulse:_____

Medications:_____

Allergies:_____

Major Illnesses:_____

Past Surgeries:_____

General Appearance: _____

Eyes: _____ Vision: (R)_____ (L)_____

Ears:_____ Hearing: _____

Mouth/Throat:_____ Skin: _____

Lungs:_____

Abdomen:_____

Genitourinary:_____

Musculoskeletal

Spine:_____

Extremities:_____

Neurological

Reflexes:_____

Mental Status:_____

Other tests:_____

General Impression

Remarks:_____

Physician's Signature_____Date:_____

This form must be completed by a licensed physician