Physical Exam

NAME:							DATE:
Active Medications:							
Allergies: Med/Food:							
Vital Signs:	HT:	WT:	TEMP:	B/P	HR:	RR:	PAIN: 0-10
General Appearance:				Cooperative: Y/N			
Alertness/Impairment:							
HEENT:							
Head:							
Eyes:					Vision Screen:		
Ears:					Hearing Screen:		
Nose:							
Mouth/Throat:							
Neck							
Chest/Breast:					Deferred: Y/N		
Heart							
Lungs							
Abdom							
Genital/Rectal:					Deferred: Y/N		
Musc/Skel:							
Back/Spine:							
Extremities:							
DERM:							
Neurologic:							
CN: 2-12:							
Reflexes:							
Sensory:							
Motor:							
Other:							

HCP Signature: ____