

Date of Service: _____

Physical Exam

Name: _____

SSN: _____

Height: _____ Weight: _____ Temp: _____ Vision: Uncorrected Corrected Visual Fields
 B/P Resting _____ Pulse: _____ Repeat B/P _____ Near Rt _____ Near Rt _____ Rt _____°
 (2 min of ex) _____ Pulse: _____ Lt _____ Lt _____ Lt _____°
 Respirations/min _____ Distant Rt _____ Distant Rt _____ Color NL AB
 Hearing to forced whisper @ 5 ft: Rt _____ Lt _____ Lt _____ Depth Perception
 NL AB

HEENT			<u>Heart</u>			<u>Reflexes</u>		
<u>Eyes</u>			Rhythm	NL	AB	Babinski	NL	AB
Globe	NL	AB	Auscultation	NL	AB	Romberg	NEG	POS
Pupils	NL	AB	Abdomen	NL	AB	Pupillary Rt	NL	AB
EOM's	NL	AB	Abd. surg scar	N	Y	Lt	NL	AB
Funduscopy	NL	AB	<u>Hernia</u>			Accom. Rt	NL	AB
<u>Ears</u>			Umbilical	N	Y	Lt	NL	AB
Canal Clear	Y	N	Inguinal	N	Y	Biceps Rt	NL	AB
TM Visualized	Y	N	Femoral	N	Y	Lt	NL	AB
Scarring of TM	N	Y	Varicocele	N	Y	Knee Rt	NL	AB
Drainage	N	Y	Upper Extremity	NL	AB	Lt	NL	AB
Nose	NL	AB	Hands/Fingers	NL	AB	Ankle Rt	NL	AB
<u>Mouth</u>			Legs	NL	AB	Lt	NL	AB
Teeth	NL	AB	Knees	NL	AB	<u>Proprioception</u>		
Throat	NL	AB	Knee surg. scar	N	Y	UE Rt	NL	AB
Skin	NL	AB	Feet/ankles	NL	AB	Lt	NL	AB
Neck	NL	AB	Varicosities	NL	AB	LE Rt	NL	AB
Thyroid	NL	AB	Up. ext. strength	NL	AB	Lt	NL	AB
Chest wall	NL	AB	Up. ext ROM	NL	AB	<u>Sensory Examination:</u>		
Lungs	NL	AB	Low ext. ROM	NL	AB	UE Rt	NL	AB
			Back/spine ROM	NL	AB	Lt	NL	AB
			Back surg scar	N	Y	LE Rt	NL	AB
			Neurological Exam:			Lt	NL	AB
			Cran. nerves 2-12:	NL	AB			

OPTIONAL:
 Genitalia NL AB
 Breast NL AB
 Rectal NL AB

Medications: _____

Allergies: _____

PSH: _____

Comments: _____

 Provider Signature Date



HIGHLAND CLINIC

The Workplace

Date of Service: _____

Physical Exam

Name: _____

SSN: _____

EXAMINATION RESULTS

_____ Able to perform essential functions as listed

_____ No job description available at time of exam. Cleared for job duty according to verbalized description provided by patient.

_____ Unable to perform all essential functions as listed. Please list failed essential function(s):

_____ No medical restrictions are indicated.

_____ The following medical restrictions are indicated:

_____ Recommend further evaluation

Remarks: _____

Provider Signature

Provider Print Name Here