



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