Physical Exam Form

Name: _____
First Middle Last

DOB: _____ **Weight:** _____
Month Day Year

Height: _____ ft. _____ in. **BMI:** _____ **BF:**

Blood Pressure: _____ **Pulse:** _____ **Respiration:** _____ **0_2 Sat:** _____

YES	NO	Is there, on examination, any abnormality of the following:
☐	☐	Head, eyes, ears, nose, mouth, pharynx?
☐	☐	Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?
☐	☐	Nervous System (include reflexes, gait, paralysis)?
☐	☐	Heart Rate?
☐	☐	Heart Rhythm?
☐	☐	Presence of Heart Murmur?
☐	☐	Lungs?
☐	☐	Abdomen (include scars)?
☐	☐	Genitourinary system (by history)?
☐	☐	Endocrine system (include thyroid and breasts)?
☐	☐	Musculoskeletal system (include spine, joints, amputations, deformities)?
☐	☐	Are there any hernias (by history)?
☐	☐	Are you aware of (or suspect) any other medical, alcoholic or drug history?

Please rate the following on a scale of 1-10: MOOD [ ] ENERGY [ ] LIBIDO [ ]

Notes and Recommendations:

_____

_____

_____

_____

_____

_____ _____
PLEASE PRINT MEDICAL EXAMINER'S NAME PHONE NUMBER

_____
PLEASE ENTER STREET ADDRESS | CITY | STATE | ZIP CODE

_____ _____
MEDICAL EXAMINER'S SIGNATURE **DATE OF EXAM**