Essential Healthcare ACADEMY

Physical Examination

Name: ______________________________ **D.O.B:** ____________________

BP: ____/_____ **Pulse:** ______ **Respirations:** ______ **Temp:** _______ **Wt:** _______ **Ht:** _______ **BS:** ________

System Name	Normal Findings?	Comments/Description
Eyes	☐ Yes No	
Ears	☐ Yes No	
Nose	☐ Yes No	
Mouth/Throat	☐ Yes No	
Head/Face/Neck	☐ Yes No	
Breasts	☐ Yes No	
Lungs	☐ Yes No	
Cardiovascular	☐ Yes No	
Extremities	☐ Yes No	
Abdomen	☐ Yes No	
Gastrointestinal	☐ Yes No	
Musculoskeletal	☐ Yes No	
Integumentary	☐ Yes No	
Renal/Urinary	☐ Yes No	
Reproductive	☐ Yes No	
Lymphatic	☐ Yes No	
Endocrine	☐ Yes No	
Nervous System	☐ Yes No	
VISION SCREENING	☐ Yes No	Is further evaluation recommended by specialist? Yes No
HEARING SCREENING	☐ Yes No	Is further evaluation recommended by specialist? Yes No

Additional Comments: ____

Recommendations for health maintenance:*(include need for lab work, treatments, therapies, exercise, hygiene, weight control, etc*

____

Recommended diet and special instructions: ____

Limitations or restrictions for activities *(including work*day*, lifting, standing, and bending)*: **No** **Yes** *(specify)*

____

Does this person use adaptive equipment? **No** **Yes** (*specify*)*:*_______________________________

Follow- up recommended. **No** **Yes** (*specify*)*:*____

Provider Signature: ______________________________ **Date:** __________________