Patient: ______________________ Date: __________

Social Security Number: ______________________ Contact __________

BP: Pulse Resp: ________ Temp: _______ Hgt: _________ Wgt:

Vision	Right	Left	Corrected	
Near	_______	_______	Yes	No
Far	_______	_______	Yes	No
Fields	_________ °	_________ °		
Color Vision	NL _______	AB _______		

Hearing			
Whisper Test @ 5 feet	R ______	L ______	
Hearing Aid	R` ______	L ______	
Audiogram	Yes _____	No ____	
(Results Attached) _______			

Urine Dipstick Leukocytes_____ Nitrite ____ Urobilinogen____ Protein ____pH_____
Blood ______S.G.______ Ketones _____ Bilibrubin _____Glucose ____

Skin	NL	AB
Head	NL	AB
Eyes		
Globe	NL	AB
PERRLA	NL	AB
EOMs Intact	NL	AB
Ears		
Wax	NL	AB
TMs	NL	AB
Drainage	NL	AB
Nose	NL	AB
Mouth		
Teeth	NL	AB
Gums	NL	AB
Throat	NL	AB
Neck		
Tenderness	NL	AB
ROM	NL	AB
Thyroid	NL	AB
Heart		
Rhythm	NL	AB
Sounds	NL	AB

Chest Wall	NL	AB
Lungs	NL	AB
Abdomen		
Organomegaly	NL	AB
Tenderness	NL	AB
Scars	N	Y
Hernia		
Umbilical	N	Y
Inguinal	N	Y
Femoral	N	Y
Upper Extremiites		
Strength	NL	AB
R.O.M.	NL	AB
Pulses	NL	AB
Lower Extremities		
Strength	NL	AB
R.O.M.	NL	AB
Pulses	NL	AB
Back		
Scars	N	Y
R.O.M.	NL	AB

Neurological			
C.N. 2-12		NL	AB
Romberg		Neg	Pos
Biceps	R	NL	AB
	L	NL	AB
Knee	R	NL	AB
	L	NL	AB
Ankle	R	NL	AB
	L	NL	AB
Proprioception			
Upper Ext.	R	NL	AB
	L	NL	AB
Lower Ext.	R	NL	AB
	L	NL	AB
Sensory			
Upper. Ext	R	NL	AB
	L	NL	AB
Lower Ext.	R	NL	AB
	L	NL	AB
Optional			
Genitalia		NL	AB
Fundiscopic		NL	AB
Breast		NL	AB
Rectal		NL	AB

Comments: ____

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Examiner's Signature ______________________________ Date ______________