

Physical Exam

Name: _____ Exam date: _____
First Middle Last

DOB: _____ Soc. Sec. #: _____
Month Day Year

Height: _____ ft. _____ in. Weight: _____

Blood Pressure: _____ Pulse: _____ Respiration: _____ O₂ Sat: _____

Patient History:	YES	NO
Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Any disorder of the prostate, bladder, kidneys or genitourinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema? If yes, explain: _____	<input type="checkbox"/>	<input type="checkbox"/>

(Patient has the option to defer specific tests at their discretion.)

On examination, is there any abnormality of the following:	YES	NO
Head, eyes, ears, nose, mouth, pharynx?	<input type="checkbox"/>	<input type="checkbox"/>
Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System (include reflexes, gait, paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rate?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rhythm?	<input type="checkbox"/>	<input type="checkbox"/>
Presence of Heart Murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Lungs?	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen (include scars)?	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary system (by history)?	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine system (include thyroid and breasts)?	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal system (include spine, joints, amputations, deformities)?	<input type="checkbox"/>	<input type="checkbox"/>
■ Prostate Exam (optional): <input type="checkbox"/> nl / <input type="checkbox"/> abnormal _____		
■ Fecal Occult Blood Test (optional): <input type="checkbox"/> NEG / <input type="checkbox"/> POS		

Doctor's Notes:

I have examined the patient and refer him/her to the supervising physician at Palm Beach Preventive Medicine. I understand that, upon referral, the supervising physician will assume responsibility for the patient as it pertains to the care that he/she provides. The patient understands that all further tests and subsequent care will be provided by the supervising physician at Palm Beach Preventive Medicine.

Physician's signature

Physician's printed name

Physician's phone number

Physician's email address

(Please fax the completed and signed form to 561-354-2744)