Date of Exam:_____ Age:_____ BMI:_____

Ht:_____ Wt: _____ BP: _____ Pulse: _____ Resp. Rate: _____Head Circ.:_____

BODY SYSTEM	Abnormalities noted?		FINDINGS/COMMENTS
	YES	NO	
Skin			
Head			
Eyes/Vision			Rt. Eye____ Lt. Eye____ Both eyes_____
ENT/Hearing			Whisper Test: Pass____Fail____
Oral Cavity/Teeth			
Heart			
Lung			
Abdomen			
Liver or Spleen Enlargement			
Lymph Nodes			
Musculoskeletal			
Extremities			
Neurological			
Genital			

Indicate with an "X" whether or not any abnormalities are noted for each body system.

Person Completing Physical Exam/Assessment:

_____ _____

(Printed Name and Title) (Signature)

Referrals:

☐Diabetes ☐HTN ☐Mental Health ☐Suicidal Thoughts ☐Neurology

☐GI Issues ☐Orthopedics ☐OBGYN ☐Infectious Disease ☐HIV

☐Elevated Cholesterol ☐Disability Services

☐Other (specify)_____

Was the client referred/linked to a Primary Care Provider? ☐Yes ☐No

Place Patient label here