

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