

# Physical Exam Form

Name: \_\_\_\_\_  
First Middle Last

DOB: \_\_\_\_\_  
Month Day Year

Weight: \_\_\_\_\_

Height: \_\_\_\_\_  
ft. in.

BMI: \_\_\_\_\_      BF: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ O<sub>2</sub> Sat: \_\_\_\_\_

**YES   NO   Is there, on examination, any abnormality of the following:**

- Head, eyes, ears, nose, mouth, pharynx?
- Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?
- Nervous System (include reflexes, gait, paralysis)?
- Heart Rate?
- Heart Rhythm?
- Presence of Heart Murmur?
- Lungs?
- Abdomen (include scars)?
- Genitourinary system (by history)?
- Endocrine system (include thyroid and breasts)?
- Musculoskeletal system (include spine, joints, amputations, deformities)?
- Are there any hernias (by history)?
- Are you aware of (or suspect) any other medical, alcoholic or drug history?

Please rate the following on a scale of 1-10:    MOOD [     ]    ENERGY [     ]    LIBIDO [     ]

**Notes and Recommendations:**

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_____ <small>PLEASE PRINT MEDICAL EXAMINER'S NAME</small>	_____ <small>PHONE NUMBER</small>
_____ <small>PLEASE ENTER STREET ADDRESS</small>	_____ <small>CITY                 STATE         ZIP CODE</small>
_____ <small>MEDICAL EXAMINER'S SIGNATURE</small>	_____ <small>DATE OF EXAM</small>