

Physical Examination

Date:

Patient's Name:

HEALTH HISTORY

List down all the diseases, conditions, and illnesses you have/had:

List down all of the surgeries or immunization you had:

List down all of the medicines, vitamins, and minerals you're currently taking:

List down your family history of diseases, disorders, etc.:

List down the results of recent tests or tests relevant to your symptoms:

List down the name and contact information of doctors you have seen recently:

Describe your lifestyle (eating, exercise, tobacco/alcohol use, sexual/reproductive history):

Do you have any implanted device that helps you out?

☐ Yes

☐ No

If yes, what is it? _____

List down or describe the signs, symptoms, or pain you're experiencing right now:

Do you have any additional questions?

REVIEW

Height:

Weight:

Blood Pressure:

Heart Rate/Pulse:

Temperature:

Skin:

☐ Normal

☐ Abnormal

Description: _____

Eyes:

☐ Normal

☐ Abnormal

Description: _____

Nose:

☐ Normal

☐ Abnormal

Description: _____

Mouth:☐ Normal☐ Abnormal

Description: _____

Throat:☐ Normal☐ Abnormal

Description: _____

Ears:☐ Normal☐ Abnormal

Description: _____

Heart:☐ Normal☐ Abnormal

Description: _____

Lungs:☐ Normal☐ Abnormal

Description: _____

Abdomen:☐ Normal☐ Abnormal

Description: _____

Lymph Nodes:☐ Normal☐ Abnormal

Description: _____

Pulses (Neck, Groin, etc.):☐ Normal☐ Abnormal

Description: _____

Reflexes:☐ Normal☐ Abnormal

Description: _____

OTHER EXAMS:☐ Skin Exam☐ Clinical Breast Exam☐ Digital Rectal Exam (DRE)☐ Pap Test☐ Pelvic Exam☐ Scrotum and Testicles☐ Others: _____**Results:****LABORATORY TESTS:**☐ Blood Test☐ Urine Specimen☐ Stool☐ Sputum☐ Others: _____**IMAGING STUDIES:**☐ X-ray

- ☐ Computer Tomography (CT)
- ☐ Magnetic Resonance (MRI)
- ☐ Electrocardiogram (EKG)
- ☐ Others: _____

Specialized and In-depth Diagnostic Results:

Patient's Signature: _____

Examiner's Signature: _____