Physical Exam Documentation

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Medical Record Number: _____

Chief Complaint:

VITAL SIGNS

Blood Pressure: _____ Heart Rate: _____

Respiratory Rate: _____ Temperature: _____

GENERAL APPEARANCE

General Appearance:

HEAD AND NECK EXAMINATION

Head: _____ Eyes: _____

Ears: _____ Nose and Sinuses: _____

Mouth and Throat: _____

CARDIOVASCULAR EXAMINATION

Heart Sounds: _____ Peripheral Pulses: _____

Edema: _____

RESPIRATORY EXAMINATION

Breath Sounds: _____ Respiratory Effort: _____

ABDOMINAL EXAMINATION

Inspection: _____ Palpation: _____

Auscultation: _____

NEUROLOGICAL EXAMINATION

Mental Status: _____ Cranial Nerves: _____

Motor and Sensory: _____ Reflexes: _____

MUSCULOSKELETAL EXAMINATION

Joints: _____ Muscles: _____

Spine: _____

SKIN EXAMINATION

Color: _____ Lesions: _____

ASSESSMENT AND PLAN

Clinical Impressions:

Plan of Care:

Patient Education:

Follow-Up Recommendations:

Provider's Signature:

Date of Examination: _____ dd / mm / yyyy Time of Examination: _____