Patient: ______________________________ DOB: _________________ Date: ______________________

Allergies: ____

PMH: ____

PSH: ____

MEDS: ____

SOC: ____

FMHX: ____

BP: ___________ P: _________ R: ________ T: _________ HT: ________ WT: ________

Physical Exam (Circle if WNL or "+" for positive and "-" for negative)

- **Gen** WNL + -
- **Skin** WNL + -
- **Heent** WNL + -
- **Heart** WNL + -
- **Lungs** WNL + -
- **Thyroid** WNL Enlarged ___ Nodules ___
- **Neuro** WNL + -

Abdominal (Circle one)

- **Bowel Sounds Normal** Yes No
- **Distention** Yes No
- **Hepatosplenomegaly** Yes No

Reflexes

DTR	Left			Right		
Biceps	Hypo	Normal	Hyper	Hypo	Normal	Hyper
Triceps	Hypo	Normal	Hyper	Hypo	Normal	Hyper
Brachio	Hypo	Normal	Hyper	Hypo	Normal	Hyper
Patella	Hypo	Normal	Hyper	Hypo	Normal	Hyper
Achilles	Hypo	Normal	Hyper	Hypo	Normal	Hyper

Physician Name: ____ Phone Number: ______________________________

Physician Signature: _____________________________________ Date: ______________________________