

MEDICAL HISTORY

ADDITIONAL NOTES



PHYSICAL EXAM

VITAL SIGNS	HT	WT	BMI	BP SUPINE	BP SITTING	PULSE	RESP RATE	TEMP	°
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GENERAL APPEARANCE

EXAMINATION	NORM	ABN	
1) HEAD / SCALP	<input type="checkbox"/>	<input type="checkbox"/>	
2) EYES	<input type="checkbox"/>	<input type="checkbox"/>	
A) FUNDI	<input type="checkbox"/>	<input type="checkbox"/>	
3) EARS	<input type="checkbox"/>	<input type="checkbox"/>	
4) NOSE / THROAT	<input type="checkbox"/>	<input type="checkbox"/>	
5) NECK	<input type="checkbox"/>	<input type="checkbox"/>	
A) THYROID	<input type="checkbox"/>	<input type="checkbox"/>	
6) HEART	<input type="checkbox"/>	<input type="checkbox"/>	
7) LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	
8) ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	
9) RECTAL	<input type="checkbox"/>	<input type="checkbox"/>	
A) PROSTATE	<input type="checkbox"/>	<input type="checkbox"/>	
10) EXTREMITIES	<input type="checkbox"/>	<input type="checkbox"/>	
A) PULSES	<input type="checkbox"/>	<input type="checkbox"/>	
11) NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	
A) DTR	<input type="checkbox"/>	<input type="checkbox"/>	
12) JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	
13) GENITALIA	<input type="checkbox"/>	<input type="checkbox"/>	
14) BREASTS	<input type="checkbox"/>	<input type="checkbox"/>	

LAB TESTS	URINALYSIS -	COLOR	S.GR	pH	PROT	KETO	BILI	BLOOD	NITRITE	UROB	MICRO -	OTHER TESTS / COMMENTS
Hgb												
CHOLEST	HDL - CHOL											
STOOL O.B.	PAP TEST											

ASSESSMENT

PLANS
