



# Physical Examination Form

## ALL OPERATOR PROGRAMS

Please type or print neatly.

NAME: FIRST _____		MIDDLE _____		LAST _____	
SOCIAL SECURITY # _____		DATE OF EXAMINATION _____			
MAILING ADDRESS _____				PHONE _____	
CITY _____				STATE _____ ZIP _____	

### HEALTH HISTORY

Yes	No	Yes	No	Yes	No						
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, fits, convulsions, or fainting	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extensive confinement by illness or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other nervous disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disorder	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ethanol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Permanent defect from illness, disease, or injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rx drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN _____ _____
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### GENERAL APPEARANCE AND DEVELOPMENT:

<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<input type="checkbox"/> Without corrective lenses	<input type="checkbox"/> With corrective lenses	

<b>VISION:</b>	For distance	<input type="checkbox"/> Right/20	<input type="checkbox"/> Left/20	<input type="checkbox"/> Both/20	
	Evidence of disease or injury:	Right _____	Left _____		
	Color test:	Right _____	Left _____		
	Horizontal field of vision:	Right _____	Left _____		

<b>HEARING:</b>	Right ear _____	Left ear _____
	Evidence of disease or injury:	Right ear _____ Left ear _____

<b>AUDIOMETRIC TEST:</b>	<input type="checkbox"/> 500 HZ	<input type="checkbox"/> 1000 HZ	<input type="checkbox"/> 2000 HZ	<input type="checkbox"/> 3000 HZ	<input type="checkbox"/> 4000 HZ
		<input type="checkbox"/> 5000 HZ	<input type="checkbox"/> 6000 HZ	<input type="checkbox"/> 7000 HZ	<input type="checkbox"/> 8000 HZ

**THROAT:** \_\_\_\_\_

<b>THORAX:</b>	Heart: _____
	If organic disease is present, is it fully compensated? _____
	Blood pressure:                      Systolic _____ Diastolic _____
	Pulse:                      Before exercise _____ Immediately after _____
	Lungs: _____

**ABDOMEN:** Scars \_\_\_\_\_ Abdominal masses \_\_\_\_\_ Tenderness \_\_\_\_\_

# Sample Physical Exam Form

**R Barnett**

A red circular graphic with a gradient, appearing as a stylized arrow or a partial circle, located to the right of the name 'R Barnett'.

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