



# 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"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                                                      |
|------------------------------------------------------|
| IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE EXPLAIN |
|                                                      |
|                                                      |

|                                            |                                                               |                                  |                                  |                                                    |
|--------------------------------------------|---------------------------------------------------------------|----------------------------------|----------------------------------|----------------------------------------------------|
| <b>GENERAL APPEARANCE AND DEVELOPMENT:</b> |                                                               | <input type="checkbox"/> Good    | <input type="checkbox"/> Fair    | <input type="checkbox"/> Poor                      |
| <b>VISION:</b>                             | For distance <input type="checkbox"/> Right/20                | <input type="checkbox"/> Left/20 | <input type="checkbox"/> Both/20 | <input type="checkbox"/> Without corrective lenses |
|                                            |                                                               |                                  |                                  | <input type="checkbox"/> With corrective lenses    |
|                                            | 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"/> 5000 HZ | <input type="checkbox"/> 6000 HZ | <input type="checkbox"/> 7000 HZ                   |
| <b>THROAT:</b>                             | _____                                                         |                                  |                                  |                                                    |
| <b>THORAX:</b>                             | Heart: _____                                                  |                                  |                                  |                                                    |
|                                            | If organic disease is present, is it fully compensated? _____ |                                  |                                  |                                                    |
|                                            | Blood pressure:                                               | Systolic _____                   | Diastolic _____                  |                                                    |
|                                            | Pulse:                                                        | Before exercise _____            | Immediately after _____          |                                                    |
|                                            | Lungs:                                                        | _____                            |                                  |                                                    |
| <b>ABDOMEN:</b>                            | Scars _____                                                   | Abdominal masses _____           | Tenderness _____                 |                                                    |

# Sample Of Physical Examination Form

**G Psacharopoulos**



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## **Table of Contents Sample Of Physical Examination Form**

1. Understanding the eBook Sample Of Physical Examination Form
  - The Rise of Digital Reading Sample Of Physical Examination Form
  - Advantages of eBooks Over Traditional Books
2. Identifying Sample Of Physical Examination Form
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Sample Of Physical Examination Form
  - User-Friendly Interface
4. Exploring eBook Recommendations from Sample Of Physical Examination Form
  - Personalized Recommendations
  - Sample Of Physical Examination Form User Reviews and Ratings
  - Sample Of Physical Examination Form and Bestseller Lists
5. Accessing Sample Of Physical Examination Form Free and Paid eBooks
  - Sample Of Physical Examination Form Public Domain eBooks
  - Sample Of Physical Examination Form eBook Subscription Services

- Sample Of Physical Examination Form Budget-Friendly Options
- 6. Navigating Sample Of Physical Examination Form eBook Formats
  - ePub, PDF, MOBI, and More
  - Sample Of Physical Examination Form Compatibility with Devices
  - Sample Of Physical Examination Form Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Sample Of Physical Examination Form
  - Highlighting and Note-Taking Sample Of Physical Examination Form
  - Interactive Elements Sample Of Physical Examination Form
- 8. Staying Engaged with Sample Of Physical Examination Form
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Sample Of Physical Examination Form
- 9. Balancing eBooks and Physical Books Sample Of Physical Examination Form
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Sample Of Physical Examination Form
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Of Physical Examination Form
  - Setting Reading Goals Sample Of Physical Examination Form
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sample Of Physical Examination Form
  - Fact-Checking eBook Content of Sample Of Physical Examination Form
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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