



PERSON	First	Middle		Last
SOCIAL SECURITY #				DATE OF EXAMINATION
MAILING ADDRESS				PHONE
CITY				STATE ZIP

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

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☐ Good      ☐ Fair      ☐ Poor  
☐ Left/20      ☐ Both/20      ☐ Without corrective lenses  
☐ With corrective lenses

<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 _____			

**HEARING:** Right ear \_\_\_\_\_ Left ear \_\_\_\_\_  
Evidence of disease or injury: Right ear \_\_\_\_\_ Left ear \_\_\_\_\_

**AUDIOMETRIC TEST:**      ☐ 500 HZ      ☐ 1000 HZ      ☐ 2000 HZ      ☐ 3000 HZ      ☐ 4000 HZ  
    ☐ 5000 HZ      ☐ 6000 HZ      ☐ 7000 HZ      ☐ 8000 HZ

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

**THORAX:** 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 Of Physical Examination Form

**Lingjun Ying**



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