



# 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"/> |
| <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 |
|                                            | Evidence of disease or injury:                                | Right _____                      | Left _____                       | <input type="checkbox"/> With corrective lenses    |
|                                            | 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 _____                 |                                                    |

# Physical Examination Form Example

**G Orfield**



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## **Table of Contents Physical Examination Form Example**

1. Understanding the eBook Physical Examination Form Example
  - The Rise of Digital Reading Physical Examination Form Example
  - Advantages of eBooks Over Traditional Books
2. Identifying Physical Examination Form Example
  - 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 Physical Examination Form Example
  - User-Friendly Interface
4. Exploring eBook Recommendations from Physical Examination Form Example
  - Personalized Recommendations
  - Physical Examination Form Example User Reviews and Ratings
  - Physical Examination Form Example and Bestseller Lists
5. Accessing Physical Examination Form Example Free and Paid eBooks

- Physical Examination Form Example Public Domain eBooks
- Physical Examination Form Example eBook Subscription Services
- Physical Examination Form Example Budget-Friendly Options
- 6. Navigating Physical Examination Form Example eBook Formats
  - ePub, PDF, MOBI, and More
  - Physical Examination Form Example Compatibility with Devices
  - Physical Examination Form Example Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Physical Examination Form Example
  - Highlighting and Note-Taking Physical Examination Form Example
  - Interactive Elements Physical Examination Form Example
- 8. Staying Engaged with Physical Examination Form Example
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Physical Examination Form Example
- 9. Balancing eBooks and Physical Books Physical Examination Form Example
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Physical Examination Form Example
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Physical Examination Form Example
  - Setting Reading Goals Physical Examination Form Example
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Physical Examination Form Example
  - Fact-Checking eBook Content of Physical Examination Form Example
  - 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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