

**Vital Signs:** Age: \_\_\_\_\_  
 Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Temperature: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_  
 Respirations: \_\_\_\_\_ Fingertick: \_\_\_\_\_ LMP: \_\_\_\_\_ Oxygen Saturation: \_\_\_\_\_ Initials: \_\_\_\_\_

**Physical Exam:**

- |   |   |   |  |   |
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| <input type="checkbox"/> NI <input type="checkbox"/> Ab <b>GENERAL</b><br><input type="checkbox"/> Appearance<br><input type="checkbox"/> VS<br><b>EYES</b><br><input type="checkbox"/> Conjunctiva / lids<br><input type="checkbox"/> Pupils (Reactivity / Accom)<br><input type="checkbox"/> Disc / Fundi<br><input type="checkbox"/> EOM<br><b>ENMT</b><br><input type="checkbox"/> Ear Inspection<br><input type="checkbox"/> TMs & Canal<br><input type="checkbox"/> Hearing (Whisper, Etc.)<br><input type="checkbox"/> Weber<br><input type="checkbox"/> Rhinne<br><input type="checkbox"/> Nasal Mucosa / Septum / Turb.<br><input type="checkbox"/> Lips / Gums / Teeth<br><input type="checkbox"/> Oropharynx<br><b>NECK</b><br><input type="checkbox"/> Appearance<br><input type="checkbox"/> Symmetry<br><input type="checkbox"/> Trachea<br><input type="checkbox"/> Thyroid<br><input type="checkbox"/> Lymph Nodes<br><b>LUNGS</b><br><input type="checkbox"/> Resp. Effort<br><input type="checkbox"/> Rib Excursion | <input type="checkbox"/> NI <input type="checkbox"/> Ab<br><input type="checkbox"/> Auscultation<br><input type="checkbox"/> Percussion<br><input type="checkbox"/> Palpation<br><b>CV</b><br><input type="checkbox"/> PMI<br><input type="checkbox"/> Palpation<br><input type="checkbox"/> Auscultation<br><input type="checkbox"/> Rhythm<br><input type="checkbox"/> Rate<br><input type="checkbox"/> S1<br><input type="checkbox"/> S2<br><input type="checkbox"/> Carotid Art.<br><input type="checkbox"/> Abd. Aorta<br><input type="checkbox"/> Fem. Pulses<br><input type="checkbox"/> Pedal Pulses<br><input type="checkbox"/> Extremities (Edema / Varicose Veins)<br><b>CHEST</b><br><input type="checkbox"/> Inspection<br><input type="checkbox"/> Palpation<br><input type="checkbox"/> Right Breast<br><input type="checkbox"/> Left Breast<br><input type="checkbox"/> Right Axillae<br><input type="checkbox"/> Left Axillae<br><b>ABDOMEN</b><br><input type="checkbox"/> Inspection | <input type="checkbox"/> NI <input type="checkbox"/> Ab<br><input type="checkbox"/> Bowel Sounds<br><input type="checkbox"/> Palpation<br><input type="checkbox"/> Liver Span<br><input type="checkbox"/> Spleen<br><input type="checkbox"/> Inguinal Area<br><b>GU - MALE</b><br><input type="checkbox"/> Scrotum / Testes<br><input type="checkbox"/> Penis<br><input type="checkbox"/> Anus<br><input type="checkbox"/> Perineum<br><input type="checkbox"/> Rectal Area (Ext.)<br><input type="checkbox"/> Prostate (DRE)<br><input type="checkbox"/> Occult Blood<br><input type="checkbox"/> GU - FEMALE<br><input type="checkbox"/> Ext. Genitalia<br><input type="checkbox"/> Urethra<br><input type="checkbox"/> Cervix<br><input type="checkbox"/> Adnexa<br><input type="checkbox"/> Uterus<br><input type="checkbox"/> Bladder<br><input type="checkbox"/> Saline / KOH<br><input type="checkbox"/> Rectal Exam<br><input type="checkbox"/> Occult Blood<br><b>LYMPH NODES</b><br><input type="checkbox"/> Neck<br><input type="checkbox"/> Supraclavicular | <input type="checkbox"/> NI <input type="checkbox"/> Ab<br><input type="checkbox"/> Axillary<br><input type="checkbox"/> Inguinal<br><input type="checkbox"/> Other _____<br><b>SKIN</b><br><input type="checkbox"/> Inspection<br><input type="checkbox"/> Palpation<br><b>NEURO</b><br><input type="checkbox"/> Cranial Nerves<br><input type="checkbox"/> Tendon Reflexes<br><input type="checkbox"/> Biceps<br><input type="checkbox"/> Triceps<br><input type="checkbox"/> Patellar<br><input type="checkbox"/> Achilles<br><input type="checkbox"/> Brachioradialis Strength<br><input type="checkbox"/> Motor Strength<br><input type="checkbox"/> Upper Ext. - Strength<br><input type="checkbox"/> Lower Ext. - Strength<br><input type="checkbox"/> Sensory<br><input type="checkbox"/> Light Touch<br><input type="checkbox"/> Pin Prick<br><input type="checkbox"/> Vibration<br><input type="checkbox"/> Temperature<br><input type="checkbox"/> Proprioception<br><input type="checkbox"/> Romberg<br><input type="checkbox"/> RAM<br><input type="checkbox"/> Babinski Eval | <input type="checkbox"/> NI <input type="checkbox"/> Ab <b>MSK</b><br><input type="checkbox"/> Inspection<br><input type="checkbox"/> Exam of Joints<br><input type="checkbox"/> Head and Neck<br><input type="checkbox"/> Spine / Ribs<br><input type="checkbox"/> Pelvis<br><input type="checkbox"/> RUE<br><input type="checkbox"/> LUE<br><input type="checkbox"/> RLL<br><input type="checkbox"/> LLE<br><input type="checkbox"/> ROM<br><input type="checkbox"/> ROM<br><input type="checkbox"/> Gait<br><input type="checkbox"/> Clubbing / Cyanosis / Edema Eval<br><b>PSYCHIATRIC</b><br><input type="checkbox"/> Orientation (Person, Place, Time)<br><input type="checkbox"/> Mental Status<br><input type="checkbox"/> Judgment<br><input type="checkbox"/> Insight<br><input type="checkbox"/> Short-Term Mem<br><input type="checkbox"/> Long-Term Mem<br><input type="checkbox"/> Mood<br><input type="checkbox"/> Affect<br><input type="checkbox"/> Concentration<br><input type="checkbox"/> Speech |
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**Comments:** \_\_\_\_\_  
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**Assessment & Plan:** \_\_\_\_\_  
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- SF  L  M  H Medical Decision-Making  
 See Continuation Sheet
- |   |  |   |   |   |
|---|--|---|---|---|
| <b>Counseling</b><br><input type="checkbox"/> Advance Directives<br><input type="checkbox"/> Alcohol<br><input type="checkbox"/> BSE<br><input type="checkbox"/> Dental Care<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Domestic Violence<br><input type="checkbox"/> Exercise<br><input type="checkbox"/> Eye Protection<br><input type="checkbox"/> Foot Care<br><input type="checkbox"/> Firearms Risk<br><input type="checkbox"/> Hearing Conserv.<br><input type="checkbox"/> Hormone Replacement<br><input type="checkbox"/> Medication S / E<br><input type="checkbox"/> Noncompliance<br><input type="checkbox"/> Nutrition _____<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Pregnancy Prevention | <input type="checkbox"/> Seat Belts<br><input type="checkbox"/> Smoke Detectors<br><input type="checkbox"/> STD / HIV Counseling<br><input type="checkbox"/> Substance Abuse<br><input type="checkbox"/> Sun Protection<br><input type="checkbox"/> TSE<br><input type="checkbox"/> Tobacco Cess.<br><b>Labs Ordered</b><br><input type="checkbox"/> BMP<br><input type="checkbox"/> CBC<br><input type="checkbox"/> Cholesterol Profile<br><input type="checkbox"/> CMP<br><input type="checkbox"/> Drug Level<br><input type="checkbox"/> GC / Chlamydia<br><input type="checkbox"/> Hb A1c<br><input type="checkbox"/> Hepatic Profile<br><input type="checkbox"/> Hepatitis Serology<br><input type="checkbox"/> HIV | <input type="checkbox"/> INR<br><input type="checkbox"/> PAP<br><input type="checkbox"/> Pregnancy Test<br><input type="checkbox"/> PSA<br><input type="checkbox"/> Rapid Strep<br><input type="checkbox"/> Renal Profile<br><input type="checkbox"/> RPR<br><input type="checkbox"/> Stool Cards<br><input type="checkbox"/> TFTs<br><input type="checkbox"/> Throat Culture<br><input type="checkbox"/> Urinalysis<br><input type="checkbox"/> Urine Culture<br><input type="checkbox"/> Urine Pregnancy Test<br><input type="checkbox"/> Other _____<br><b>Tests Ordered</b><br><input type="checkbox"/> BE<br><input type="checkbox"/> Colonoscopy<br><input type="checkbox"/> CT / MRI _____ | <input type="checkbox"/> CXR<br><input type="checkbox"/> Echocardiogram<br><input type="checkbox"/> Electrocardiogram<br><input type="checkbox"/> Flex Sig<br><input type="checkbox"/> IVP<br><input type="checkbox"/> Mammogram<br><input type="checkbox"/> Stress Echo<br><input type="checkbox"/> Stress Test _____<br><input type="checkbox"/> Ultrasound<br><input type="checkbox"/> Follow Up _____<br><b>Follow Up</b><br>___ Day(s)<br>___ Week(s)<br>___ Month(s)<br>___ Prn<br><input type="checkbox"/> Pending Test(s) _____ | <b>BP Check In</b><br>___ Day(s)<br>___ Weeks(s)<br>___ Month(s)<br><b>Call Office</b><br>___ Day(s)<br>___ Week(s)<br>___ Month(s)<br>___ Prn<br><b>Labs to be Done In</b><br>___ Today<br>___ Day(s)<br>___ Week(s)<br>___ Month(s)<br><input type="checkbox"/> Old Records Requested |
|---|--|---|---|---|

Referred To \_\_\_\_\_ Time Counseling (Minutes) \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_