



Name: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Dept./Program: \_\_\_\_\_

**CLINICAL EVALUATION: CHECK EACH ITEM IN THE APPROPRIATE COLUMN; "NE" IS NOT EVALUATED**

	Normal	Abnormal	NE	Notes: Describe abnormality with pertinent numeral before comment.
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Ophthalmoscopic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Neck/thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Lymphatics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Thorax/lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Vascular system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Extremities/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Temperature: \_\_\_\_\_ Blood Pressure: Systolic: \_\_\_\_\_ Diastolic: \_\_\_\_\_ Pulse: \_\_\_\_\_

Gross Hearing: R: \_\_\_\_\_ L: \_\_\_\_\_ Corrected Vision: R: \_\_\_\_\_ L: \_\_\_\_\_

Diagnosis and assessment of medical problems:

- No Medical Problems
- Ongoing medical problems: (Explain)

Limitations/Recommendations: (Further specialist examinations, labwork, x-ray, immunizations, etc.)

- No Limitations
- Limitations: (Explain)

Printed Name of Physician/Health Care Provider: \_\_\_\_\_ Title: \_\_\_\_\_

Physician/Health Care Provider Signature: \_\_\_\_\_

Physician/Health Care Provider Address: \_\_\_\_\_

Telephone: (     ) \_\_\_\_\_