



PHYSICAL EXAMINATION FORM

NAME: _____ DATE: _____

Blood Pressure: _____ Pulse: _____ Respiration: _____ Temp: _____

General Appearance: _____

Nutritional Status: _____ Weight: _____ lbs

1. HEAD: _____ SKIN: _____

2. EYES: Vision Screening – Right Eye: _____ Left Eye: _____
Test Used: _____
Conjunctiva: _____ Sclera: _____ Cornea: _____
Pupils: _____ Lens: _____ Fundi: _____

3. EARS: Auditory Acuity – Right: _____ Left: _____ Bilateral: _____
Test Used: _____
Canals: _____ Drums: _____

4. NOSE: _____

5. MOUTH: _____

6. TEETH: _____

7. PHARYNX: _____

8. NECK: _____

9. THYROID GLAND: _____

10. LYMPH NODES: _____

11. CHEST: _____

12. LUNGS: _____

13. HEART: _____ PERIPHERAL PULSES: _____

14. BREASTS: _____

15. ABDOMEN: _____

16. GENITALIA: _____ HERNIA: _____

17. RECTAL: _____

18. EXTREMITIES: _____

19. NEUROLOGICAL:

Orientation: _____
State of Consciousness: _____
Cranial Nerves: _____
DTR: _____
Pathological Reflexes: _____
Muscle Strength: _____
Gait: _____
Tone: _____
Involuntary Movements: _____

20. JOINTS (contractures): _____

21. SPINE (describe any curvature): _____

22. TARDIVE DYSKINESIA (if individual is receiving behavior modifying medications, or others which can cause TD, at the time of examination or within the past year): _____

PPD TEST PLACED: Right arm: _____ Left arm: _____

FORM CONTINUES ON REVERSE →

Return to office or complete return card for result on (date): _____

IMPRESSION:

DIAGNOSIS:

RECOMMENDATIONS:

Printed Name of Examiner

Signature of Examiner

Date

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