

Adult Physical Examination Form

Patient Information

Full Name

Date of Birth

Sex

Exam Date

Provider Name

Medical Record #

Vital Signs

Height cm / in

Weight kg / lbs

BMI

Blood Pressure mmHg

Pulse bpm

Temperature °C / °F

Respiration per min

General Appearance

Appearance, distress, hygiene, etc.

Physical Examination

Head and Neck

Eyes

Ears/Nose/Throat

Cardiovascular

Respiratory	<input type="text"/>
Abdomen	<input type="text"/>
Musculoskeletal	<input type="text"/>
Skin	<input type="text"/>
Neurological	<input type="text"/>
Psychiatric	<input type="text"/>

Assessment & Plan

Summary, diagnoses, plan, recommendations

Provider Signature

Signature

Date
