spectrum | Annual Physical Exam

Client Name:	DOB:	
Physician:	vsician: Appointment Date:	
Provider Reporting:		
Location:		Phone:
	– Medical Professional Only	<i>y</i> –
Diagnosis:		
•		
Height: Weight:	Blood Pressure: _	Pulse:
Vision/Audiology Exam con	npleted during visit? Yes	/ No
MEDICATION:	DOSAGE:	REASON:

GENERAL APPEARANCE	WITHIN NORMAL LIMITS?	CONCERNS/NOTES
Head		
Eyes		
Ears		
Nose		
Oral Cavity		
Neck		
Lungs		
Cardiovascular		
Abdomen		
Genitalia		
Skin		
Muscular-Skeletal (strength, tone, bulk, posture, gait, etc.)		
Notes:		
Physician Signature: _		Date:
Agency Nurse Review:		Date: