Annual Physical

To be completed by physician

Name: _____ DOB: _____

Allergies: _____

Vital Signs

Height: _____ Weight: _____

Physical Exam

(For each system, circle Y or N. If abnormal, describe.)

General Appearance: Y / N – If abnormal, describe: _____

Neurological: Y / N – If abnormal, describe: _____

HEENT: Y / N – If abnormal, describe: _____

Cardiovascular: Y / N – If abnormal, describe: _____

Pulmonary: Y / N – If abnormal, describe: _____

Abdominal: Y / N – If abnormal, describe: _____

Musculoskeletal: Y / N – If abnormal, describe: _____

Extremities/Skin: Y / N – If abnormal, describe: _____

Genitourinary: Y / N – If abnormal, describe: _____

Comments: _____

Any changes in health since last physical? Y / N

_____

Concern for communicable disease? Y / N

_____

Any restrictions on activity? Y / N — if yes, describe: _____

Please attach an updated medication list and/or immunization record.

_____ _____

Physician's Signature Date

_____

Office Phone Number