Physical Exam

Name: _____ **Exam date:** _____
First Middle Last

DOB: _____ **Soc. Sec. #:** ___ - ___ - ____
Month Day Year

Height: ft. in. **Weight:** _____

Blood Pressure: _____ **Pulse:** _____ **Respiration:** _____ **0_2 Sat:** _____

Patient History:	YES	NO
Any disorder of the heart or blood vessels, e.g., heart attack, angina pectoris, stroke, palpitations, elevated blood pressure, shortness of breath, chest pain, irregular pulse or varicose veins? If yes, explain:	☐	☐
Any disease of the stomach, liver, intestines or rectum, e.g., ulcers, gallbladder disease, bleeding from intestinal tract, colitis, diverticulitis or appendicitis? If yes, explain:	☐	☐
Any disorder of the prostate, bladder, kidneys or genitourinary tract, e.g., nephritis, sugar, protein or pus in urine, venereal disease, kidney stones or colic? If yes, explain:	☐	☐
Anything else, e.g., cancer, cyst or tumor, blood disorder, hypoglycemia, diabetes, glandular condition, e.g., thyroid, hernia, skin disease or eczema? If yes, explain:	☐	☐

(Patient has the option to defer specific tests at their discretion.)

On examination, is there any abnormality of the following:	YES	NO
Head, eyes, ears, nose, mouth, pharynx?	☐	☐
Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
Nervous System (include reflexes, gait, paralysis)?	☐	☐
Heart Rate?	☐	☐
Heart Rhythm?	☐	☐
Presence of Heart Murmur?	☐	☐
Lungs?	☐	☐
Abdomen (include scars)?	☐	☐
Genitourinary system (by history)?	☐	☐
Endocrine system (include thyroid and breasts)?	☐	☐
Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐

■ Prostate Exam (optional): ☐nl / ☐abnormal _____

■ Fecal Occult Blood Test (optional): ☐NEG / ☐POS

Doctor's Notes:

I have examined the patient and refer him/her to the supervising physician at Ageless Medicine of the Palm Beaches. I understand that, upon referral, the supervising physician will assume responsibility for the patient as it pertains to the care that he/she provides. The patient understands that all further tests and subsequent care will be provided by the supervising physician at Ageless Medicine of the Palm Beaches.

Physician's signature

Physician's printed name

Physician's phone number

Physician's email address

Please complete. sign, print, and bring to your first appointment.