PHYSICAL EXAMINATION

NAME: _____ DOB: _____ AGE: _____

HEIGHT:_____ WEIGHT: _____ B/P: _____ PULSE: _____ RESP: _____

GENERAL APPERANCE: _____

SKIN (SCABIES): _____

HAIR/SCALP (LICE): _____

EYES RIGHT: _____ VISION RIGHT: _____

LEFT: _____ LEFT: _____

EARS: _____ NOSE: _____

MOUTH/TEETH: _____ THROAT: _____

NECK: _____ BREAST: _____

CHEST: _____ HEART: _____

LUNGS: _____ ABDOMEN: _____

HERNIA: _____ EXTREMITIES: _____

SPINE: _____ GENITALIA: _____

PELVIC: _____ PREGNANCY: _____

LAST MENSTRAL PERIOD: _____

COMMUNICIABLE DISEASES: _____

_____

TB SKIN TEST (DATE): _____ NEGATIVE: _____ POSITIVE: _____

POSITEIVE REACTOR: _____ CURRENT CHEST E-RAY REPORT: _____

LAB WORK: Y N _____

HEPATITIS PROFILE: Y N _____

IMPRESSION: _____

_____

TREATMENT: _____

_____

MEDICATIONS: _____

_____

SIGNIFICANT FINDINGS/COMMENTS: _____

_____

_____

REFERRALS: _____

_____

RECOMMENDED FOR INPATIENT SUBSTANCE ABUSE TREATMENT: YES NO

PHYSICIAN' SIGNATURE: _____ DATE: _____