McLaren Medical Group

ADULT PHYSICAL EXAMINATION

Name:	Age:	Date of Birth:	Date of Service:

Chief Complaint:

BP:	HT:	Temp:	LMP:
Pulse:	WT:	RESP:	Urine:

REVIEW OF SYSTEMS	PHYSICAL EXAMINATION	FINDINGS
CONSTITUTIONAL SYMPTOMS (fever, weight loss, etc.)	GENERAL APPEARANCE	
EYES		
EARS, NOSE, MOUTH, THROAT	EYES	
CARDIOVASCULAR	EARS/NOSE/MOUTH/THROAT	
RESPIRATORY	NECK	
	RESPIRATORY	
GASTROINTESTINAL		
GENITOURINARY	CARDIOVASCULAR	
MUSCULOSKELETAL		
	CHEST (BREASTS)	
SKIN AND/OR BREAST		
	GASTROINTESTINAL (ABDOMEN)	
NEUROLOGICAL		
PSYCHIATRIC		
	GENITOURINARY	
ENDOCRINE		
HEMATOLOGIC/LYMPHATIC		
ALLERGIC/IMMUNOLOGIC	LYMPHATIC	
	MUSCULOSKELETAL	
Signature (if not completed by physician)		
IMPRESSION:	SKIN	
PLAN:	NEUROLOGICAL	
FOLLOW-UP:		
	PSYCHIATRIC	

Physician's Signature _____

Date: _____