

PHYSICAL EXAMINATION

Name _____ Date of Birth _____

Height _____ Weight _____ % Body fat (optional) _____ Pulse _____

BP _____

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitals (males only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

- Cleared
- Cleared after completing evaluation/rehabilitation for:

Not cleared for: _____ Reason: _____

Recommendations: _____

 Name of Physician (print) _____ Date _____

Address _____ Phone _____

PHYSICAL EXAMINATION

Signature of Physician _____ MD DO