



Ambert Medical Care Center

15495 Eagle Nest LN Suite 100
Miami Lakes FL 33014
Ph: 305-556-0021 Fax: 305-556-0071
Email: ambertmedcare@hotmail.com

PHYSICAL EXAMINATION FORM

Name Taira Magdalena Date of birth 12/7/1977

Examination		
Height <u>63.5 inch</u>	Weight <u>280 lbs</u>	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
BP <u>117/80</u>	Pulse <u>70 bpm</u>	
Medical	Normal Findings?	Comments/Description
Appearance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes/Ears/Nose/Throat	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Lymph Nodes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Heart	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulses	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulses Lungs	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Abdomen	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Genitourinary (Males Only)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Skin	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Tinea Corporis Neurologic	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Musculoskeletal		
Neck	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Back Shoulders	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Elbow/Forearm	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Wrist/Hands/Fingers	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Hip/Thighs	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Knee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Leg/Ankle	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Foot/Toes	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	

☒ Cleared without restriction

Not cleared

☐ Pending further evaluation

☐ With Restrictions

Reason: _____

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Recommendations: TB screening negative Quantiferon - See attached

I have examined the above-named patient and completed the physical evaluation. A copy of the physical exam is on record in my office and can be made available at the request of the parents. If conditions arise after the patient has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the parents.

Name of physician (print/type) Taira Magdalena

Date 9/12/2022

Signature of physician _____

Office Stamp: _____