

Physical Examination

☒ Check normal, circle & describe abnormal

Name:

Date:

General ☐ WNL

- ☐ Posture ☐ Appearance
- ☐ Gait ☐ Emotion
- ☐ Speech

Skin ☐ WNL

- ☐ Scars ☐ Sweat
- ☐ Marks ☐ Color
- ☐ Texture ☐ Ulcers
- ☐ Temperature ☐ Moles/pigmentation

Head ☐ WNL

- ☐ Hair ☐ Tenderness
- ☐ Shape ☐ Bruits
- ☐ Masses ☐ Sinuses

Neck ☐ WNL

- ☐ Skin ☐ R ☐ L
- ☐ Thyroid ☐ Lymph nodes
- ☐ Veins ☐ Bruits
- ☐ Spine ☐ Carotids
- ☐ Posture ☐ Rotation
- ☐ Resisted ROM ☐ Lat. flexion

Eyes ☐ WNL

- | | |
|--------------------------------------|-----------------------------------|
| R L | R L |
| <input type="checkbox"/> Lids | <input type="checkbox"/> Pupils |
| <input type="checkbox"/> Sclera | <input type="checkbox"/> Fundi |
| <input type="checkbox"/> Conjunctiva | <input type="checkbox"/> PERRLA |
| <input type="checkbox"/> Muscles | <input type="checkbox"/> Pressure |
| <input type="checkbox"/> Cornea | <input type="checkbox"/> Acuity |

Ears ☐ WNL

- | | |
|--------------------------------|---------------------------------|
| R L | R L |
| <input type="checkbox"/> Pinna | <input type="checkbox"/> Weber |
| <input type="checkbox"/> Canal | <input type="checkbox"/> Rinne |
| <input type="checkbox"/> Drum | <input type="checkbox"/> Acuity |

Nose ☐ WNL

- | | |
|--------------------------------------|------------------------------------|
| L R | R L |
| <input type="checkbox"/> Nares | <input type="checkbox"/> Septum |
| <input type="checkbox"/> Mucosa | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Obstruction | |

Mouth/throat ☐ WNL

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Lips | <input type="checkbox"/> Teeth |
| <input type="checkbox"/> Breath | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Tongue | <input type="checkbox"/> Caries |
| <input type="checkbox"/> Pharynx | <input type="checkbox"/> Larynx |
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Floor of mouth |

Lungs ☐ WNL

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Chest | <input type="checkbox"/> Bruits |
| <input type="checkbox"/> Symmetry | <input type="checkbox"/> Sounds |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Fremitus |
| <input type="checkbox"/> Rubs | <input type="checkbox"/> Resp. effort |
| <input type="checkbox"/> Excursion | <input type="checkbox"/> Rate _____ |

Back ☐ WNL

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Skin | R L |
| <input type="checkbox"/> Curvature | <input type="checkbox"/> Muscle mass |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Shoulder height |
| <input type="checkbox"/> Masses | <input type="checkbox"/> Iliac crest height |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Resisted ROM |

Heart ☐ WNL

- | | |
|----------------------------------|---|
| <input type="checkbox"/> PMI | <input type="checkbox"/> Auscultation |
| <input type="checkbox"/> Rhythm | <input type="checkbox"/> Rate _____ |
| <input type="checkbox"/> Thrills | <input type="checkbox"/> Blood pressure |
| <input type="checkbox"/> Rub | |
| <input type="checkbox"/> Murmur | |

Breasts ☐ WNL

- | | |
|------------------------------------|--------------------------------------|
| R L | R L |
| <input type="checkbox"/> Symmetry | <input type="checkbox"/> Lymph nodes |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Nipple |
| <input type="checkbox"/> Contour | <input type="checkbox"/> Areola |
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Pain |

Abdomen ☐ WNL

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Skin | R L |
| <input type="checkbox"/> Sounds | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Masses | <input type="checkbox"/> Bruits |
| <input type="checkbox"/> Tenderness | <input type="checkbox"/> Femoral pulse |
| <input type="checkbox"/> Organs | <input type="checkbox"/> Inguinal nodes |
| <input type="checkbox"/> Resisted ROM | <input type="checkbox"/> Murphy's punch |

Female Genitalia ☐ WNL

- | | |
|---|---|
| <input type="checkbox"/> Labia | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Bartholin glands | <input type="checkbox"/> Ovaries |
| <input type="checkbox"/> Urethra | <input type="checkbox"/> Adnexa |
| <input type="checkbox"/> Vagina | L: _____ R: _____ |
| <input type="checkbox"/> Cervix | <input type="checkbox"/> PAP smear done |

Male Genitalia ☐ WNL

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Penis | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Scrotum | <input type="checkbox"/> Meatus |
| <input type="checkbox"/> Testicles | <input type="checkbox"/> Epididymus |
| <input type="checkbox"/> Discharge | <input type="checkbox"/> Lesions |

Rectal ☐ WNL

- | | |
|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Masses | <input type="checkbox"/> Fissure |
| <input type="checkbox"/> Anus | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Sphincter | <input type="checkbox"/> Aniscope |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Sigmoid |
| <input type="checkbox"/> Pilonidal | <input type="checkbox"/> Mucosa |

Neurologic ☐ WNL

	R - strength - L		R - reflexes - L	
Biceps (C5-C6)				
Triceps (C7-C8)				
Knee (L3-L4)				
Ankle (L5-S1)				

Strength grade: weak (W), normal (N), strong (S)
Reflexes grade: absent (A), present (P), brisk (B), clonus (C)

R L

- ☐ Cranial nerves
- ☐ Sensation
- ☐ Coordination
- ☐ Tremor
- ☐ Vibration
- ☐ Babinski
- ☐ Romberg

Extremities ☐ WNL

- | | | | |
|---------------------------------------|---------------------------------------|------------------------------------|--------------------------------------|
| R L | R L | R L | R L |
| <input type="checkbox"/> Color | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hand | <input type="checkbox"/> Knee |
| <input type="checkbox"/> General | <input type="checkbox"/> Arm | <input type="checkbox"/> Fingers | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Motion | <input type="checkbox"/> Elbow | <input type="checkbox"/> Nails | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Radial pulse | <input type="checkbox"/> Hip | <input type="checkbox"/> Pedal pulse |
| <input type="checkbox"/> Varicosities | <input type="checkbox"/> Wrist | <input type="checkbox"/> Thigh/leg | <input type="checkbox"/> Toes/nails |

Signature: