Defy MEDICAL

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Sports / Activity

PHYSICAL EXAM FORM

Dear Practitioner,

We request that you perform a physical exam for purposes of potential treatment through our preventative and wellness care clinic. Any recommendations, records, and results from such treatments may be forwarded to your practice for your own records and information upon your request and the consent of this patient.

THIS FORM MUST BE COMPLETED BY AN M.D., D.O., NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT AND PATIENT MUST PRESENT A VALID GOVERNMENT ID WITH SIGNATURE.

(PLEASE PRINT)

Date_____ Patient Name_____

Age _____ Date of Birth _____ Height _____ Weight _____

Blood Pressure _____ Pulse _____ Temp _____

Current Medications: _____

Allergies: _____

Medical & Surgical Hx: _____

Review of Systems (please document any abnormalities): _____

_____

PHYSICAL EXAM		
HEENT:	NORMAL	ABNORMAL:
Cardiovascular:	NORMAL	ABNORMAL:
Respiratory:	NORMAL	ABNORMAL:
Gastrointestinal:	NORMAL	ABNORMAL:
Musculoskeletal:	NORMAL	ABNORMAL:
Skin:	NORMAL	ABNORMAL:
Neurological:	NORMAL	ABNORMAL:
Genitourinary:	NORMAL	ABNORMAL:

Physician's Signature _____

Physician's Name & Designation _____

Physician's Address_____

Physician's Phone _____

STAMP HERE	I (patient) acknowledge that I _____ have been examined by the physician as indicated above.