Date of Medical Examination: _____

Name: _____

Address: _____
(Street) (City) (Zip Code)

Date of Birth: _____ Sex: ☐ Male ☐ Female

Diagnosis:_____

General Physical Description:_____

Known Allergies: _____

Please fill information in for all areas that apply:

Temperature_____ Height_____ Weight_____ Blood Pressure_____ Pulse_____

Respiration_____ Cholesterol_____ Eyes_____ Nose_____ Throat_____

Ears_____ Chest_____ Lungs_____ Heart_____

Male Screenings: Prostate-Specific Antigen: _____ Genital Development/Exam_____
(Please list dates) Exam: _____

Female Screenings: Pap Smear:_____ Breast Exam: _____ Mammography:_____
(Please list dates)
Genital Development/Exam_____

Other Screenings/ Tests: (Please list dates)

Vision: _____ Urinalysis: _____ Colonoscopy: _____

Hearing: _____ Sigmoidoscopy: _____ Extremities:_____

Dental: _____ Stool Occult Blood: _____ Abdomen: _____