**Time:** (using 24 hour format)  *Physical Examination not performed*

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|  |  |  |  |
| --- | --- | --- | --- |
| **Body System** | **Finding**  (check one) | **Comments**  (\*required if finding is Abnormal) | **Clinically Significant?**  **Y/N**  (\*required if finding is Abnormal) |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| *[insert body system to be examined]* | Normal  Abnormal\*  Not examined |  |  |
| Other (specify in Comments) | Normal  Abnormal\*  Not examined |  |  |

Additional Notes: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Examination performed by:**