**PHYSICAL EXAMINATION FORM**

**Region: CAR Division: Mountain Province DATE: \_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 ***Family Name First Name Middle Name***

**Permanent Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BLOOD TYPE: \_\_\_\_\_\_\_\_**

**Course & Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Civil Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**BP: \_\_\_\_\_\_ R.R: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ P.R: \_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **FAMILY HISITORY: ( ) HYPERTENSION : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) DIABETES : \_\_\_\_\_\_\_\_\_\_\_**  **( ) ASTHMA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) HEART DISEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **( ) PTB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) KIDNEY DISEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PAST HISTORY** ***FOR WOMEN:* Last Menstrual Period (first day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **SURGERIES:** |  |
| **HOSPITALIZATIONS:** |  |
| **MAINTENANCE MEDICATION** |  |
| **ALLERGIES:** |  |
| **PHYSICAL EXAMINATION** |
|  **Skin** |  |
|  **EENT** |  |
|  **Chest** |  |
|  **Heart** |  |
|  **Lungs** |  |
|  **Abdomen** |  |
|  **Extremities** |  |
|  **Genito-urinary tract** |  |
|  **CNS** |  |
| **DIAGNOSIS:** |  |
| **TREATMENT:** |  |
| **REMARKS** |  |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Client Signature Physician’s Name & Signature**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Official Designation**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Official Station**