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

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**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**