

NAME: _____ DOB: _____ DATE: _____

PROBLEM (CC): _____

MEDICATIONS: _____ No Medications

Family History: No Change _____

ALLERGIES: Medication: _____
Latex/Tape: _____
Other: _____

Social History: No Change _____

Past Medical History: No Change _____

Vitals: T _____ P _____ R _____ BP _____

Past Surgical History No Change _____

WT _____

Hospitalizations No Change _____

REVIEW OF SYSTEMS: No Change _____

PHYSICAL EXAM: No Change _____

GENERAL APPEARANCE: WNL
SKIN: WNL
HEENT: WNL
NECK: WNL
LYMPH NODES: WNL
THYROID: WNL
SPINE: WNL
RESPIRATORY: WNL
HEART: WNL
PERIPHERAL VASCULAR SYSTEM: WNL
ORIENTATION: WNL
MOOD/AFFECT: WNL

GASTROINTESTINAL: WNL
SPLEEN : WNL
LIVER: WNL
COLON: WNL
RIGHT KIDNEY: WNL
LEFT KIDNEY: WNL
BLADDER: WNL
MASSES: WNL
HERNIA: WNL
PERINEUM: WNL
ANUS: WNL

FEMALE GENITOURINARY

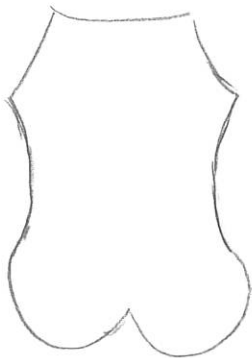
EXTERNAL GENITALIA WNL
URETHRA WNL
VAGINA WNL

MALE GENITOURINARY SYSTEM:

URETHRAL MEATUS WNL
EPIDIDYMIDES WNL
RIGHT TESTIS WNL
LEFT TESTIS WNL
____ BOTH DESCENDED
SCROTUM WNL
____ NO HYDROCELES
PENIS WNL

____ CIRCUMCISED ____ UNCIRCIMCISED

COMMENTS/EXAM NOTES:



PHYSICIAN SIGNATURE: _____