NAME: _____ DOB: _____ DATE: _____

PROBLEM (CC):

MEDICATIONS: ___No Medications

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

Vitals: T_____ P_____ R _____ BP _____

WT _____

REVIEW OF SYSTEMS: No Change ____

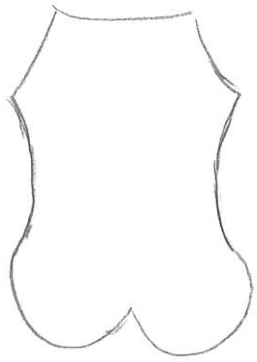
PHYSICAL EXAM: No Change ____

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

FEMALE GENITOURINARY

EXTERNAL GENITALIA	WNL
URETHRA	WNL
VAGINA	WNL

COMMENTS/EXAM NOTES:



Family History: No Change ____

Social History: No Change ____

Past Medical History: No Change ____

Past Surgical History No Change ____

Hospitalizations No Change ____

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

PHYSICIAN SIGNATURE: _____