Initial Exam / Follow up

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ BMI_____ Pulse: _____ BP: _____

History			
Chief Complaint			
Medical	**Normal**	**Abnormal Findings**	**Initials***
Heart*			
Lungs*			
Abdomen*			
Ankles /Edema*			
Foot			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Pulses			
Neck			
Back			
Shoulder/Arm			
Elbow/ Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			

All bold and * must be completed in both intial and follow up visit

Medically Cleared: YES_____ NO ___

Name of physician (print/type)_____Date_____

Address_____Phone _____

Signature of physician_____MD/DO/NP/PA-C

FAX COMPLETED FORM TO: