

ACT Physical Exam Form

Clinic Use Only			
ID	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NEWID	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date Completed	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	VISIT	Completed by <input type="text"/> <input type="text"/> (Staff code)

	Specify Abnormality
1. General Appearance <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
2. Skin <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
3. Neck (Including Thyroid) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
4. Head, ears, nose, throat <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
5. Lungs <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
6. Heart <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
7. Abdomen <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
8. Extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
9. Gait <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal →	<hr/> <hr/>
Comments: <hr/> <hr/> <hr/> <hr/>	

Should this patient be excluded as a result of physical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No EXCLUDE

ACT Follow-up Physical Exam Form

ID <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Acrostic <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date Completed <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Completed by <input type="text"/> <input type="text"/> (Staff code)

Body System	Abnormality	Present?	Comments
Heart	Murmurs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Rubs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Gallops	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs	Adventitious breath sounds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Diminished breath sounds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuromuscular	Gait	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Extremities	Clubbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Xanthoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Deformities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulses	Radial	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dorsalis Pedis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neck	Carotid bruits	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Completed by <input type="text"/> <input type="text"/> (Staff code)
