

COMPREHENSIVE PHYSICAL EXAMINATION

Blood Pressure ____/____/____ Height _____ Weight _____

Visual Acuity (C.N. II)

___ 1 Impaired peripheral vision	Rt. eye	Uncorrected	Corrected
		20/_____	20/_____
	Lt. eye	20/_____	20/_____

H E E N T AND SKIN (check abnormalities/dysfunction)

1. Head

___ 1 Masses/lumps	___ 4 Abnormal size vs body	___ 7 NORMAL
___ 2 Asymmetry	___ 5 Hair loss	
___ 3 Scalp infections/lesions	___ 6 Other _____	

2. Eyes:

External Exam

___ 1 Alignment	___ 5 Brows, lids	___ 8 Conjunctiva
___ 2 Lacrimation	___ 6 Selera	___ 9 Cornea
___ 3 Iris	___ 7 Pupils	___ 10 Direct light reaction
___ 4 Consensual light reaction		

E.O.M. (C.N. III, IV, VI)

___ 11 Cardinal fields of gaze	___ 12 Confrontation fields (lens convergence)
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Ophthalmoscope exam

___ 13 Media	___ 15 Other _____	___ 16 NORMAL
___ 14 Fundus (discs, vessels, macula, retina)		

3. Ears:

___ 1 External ear	___ 6 Ear canal	___ 10 Weber test
___ 2 Inflammation	___ 7 TM joints	___ 11 Other _____
___ 3 Exudate	___ 8 Impaired auditory acuity	___ 12 NORMAL
___ 4 Rinne Test	(C.N. VIII)	
___ 5 Ear druM	___ 9 Excess cerumen	

4. Nose:

___ 1 Patency	___ 4 Turbinates	___ 7 Other _____
___ 2 Septum	___ 5 Sinuses	___ 8 NORMAL
___ 3 Mucosa	___ 6 Discharge	

5. Mouth:

___ 1 Cavities	___ 4 C.N. IX, (gag, swallow	___ 6 Inflammation
___ 2 Bridges	cough, talk)	___ 7 Other _____
___ 3 Gums	___ 5 False teeth	___ 8 NORMAL

6. Skin:

___ 1 Fungus	___ 6 Acne	___ 11 Edema
___ 2 Staph	___ 7 Rash	___ 12 Other _____
___ 3 Cuts/scars	___ 8 Texture/turgor	___ 13 NORMAL
___ 4 Burns	___ 9 Athlete's foot	
___ 5 Herpes	___ 10 Lesions	

THORAX (check abnormalities/dysfunctions)

1. Inspection:

___ 1 Asymmetry	___ 3 Other _____	___ 4 NORMAL
___ 2 Scars		

2. Palpation:

___ 1 Masses/lumps	___ 2 Other _____	___ 3 NORMAL
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3. Percussion:

___ 1 Restricted Excursion	___ 3 Other _____	___ 4 NORMAL
___ 2 Incomplete filling		

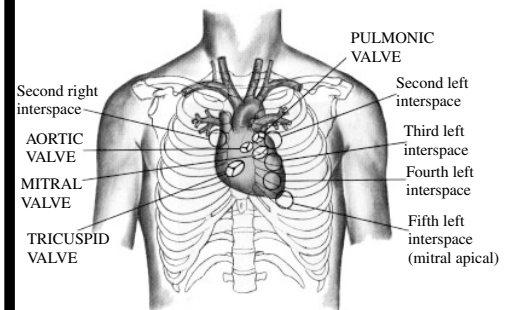
4. Auscultation:

Lungs

___ 1 Rales	___ 3 Wheezes	___ 5 NORMAL
___ 2 Ronchi	___ 4 Other _____	

Heart

___ 6 Murmurs	___ 9 Friction rub/hum	___ 12 Other _____
___ 7 Enlargement	___ 10 Displaced PMI	
___ 8 Abnormal/rate/rhythm	___ 11 Asynchrony with peripheral pulses	___ 13 NORMAL



PULSE (check if diminished/absent)

- | | | |
|-------------------------------------|---|------------------------------------|
| <input type="checkbox"/> 14 Carotid | <input type="checkbox"/> 17 Synchrony with heart beat | <input type="checkbox"/> 20 NORMAL |
| <input type="checkbox"/> 15 Femoral | <input type="checkbox"/> 18 Radial | |
| <input type="checkbox"/> 16 Aorta | <input type="checkbox"/> 19 Other _____ | |

BREAST

Female:

- | | | |
|-----------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> 1 Size | <input type="checkbox"/> 3 Nipples | <input type="checkbox"/> 5 Tenderness |
| <input type="checkbox"/> 2 Masses | <input type="checkbox"/> 4 Discharge | <input type="checkbox"/> 6 NORMAL |

Male:

- | | | |
|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> 1 Cynecomastia | <input type="checkbox"/> 3 Tenderness | <input type="checkbox"/> 4 NORMAL |
| <input type="checkbox"/> 2 Masses | | |

LYMPHATICS: (check abnormalities/dysfunctions)

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> 1 Cervical (ant. and post.) | <input type="checkbox"/> 4 Femoral | <input type="checkbox"/> 7 NORMAL |
| <input type="checkbox"/> 2 Supraclavicular | <input type="checkbox"/> 5 Suboccipital | |
| <input type="checkbox"/> 3 Axillary | <input type="checkbox"/> 6 Other _____ | |

ABDOMEN:

- | | | |
|---|--|--|
| <input type="checkbox"/> 1 Decrease/absent reflex (umbilical deviation) | | |
| <input type="checkbox"/> 2 Abnormal bowel sounds | <input type="checkbox"/> 6 Kidney pain | <input type="checkbox"/> 10 Masses |
| <input type="checkbox"/> 3 Absent bowel sounds | <input type="checkbox"/> 7 Distension | <input type="checkbox"/> 11 Aortic bruit |
| <input type="checkbox"/> 4 Rigidity | <input type="checkbox"/> 8 Liver enlargement | <input type="checkbox"/> 12 Other _____ |
| <input type="checkbox"/> 5 Spleen enlargement | <input type="checkbox"/> 9 Tenderness | <input type="checkbox"/> 13 NORMAL |

MALE GENITALIA:

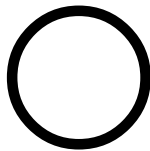
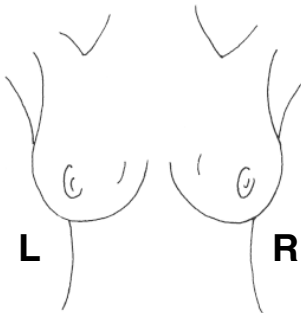
- | | | |
|--|---|--|
| <input type="checkbox"/> 1 Penile lesions | <input type="checkbox"/> 5 Impaired/absent cremasteric reflex | |
| <input type="checkbox"/> 2 Testicular masses | <input type="checkbox"/> 6 Hernia | <input type="checkbox"/> 9 Other _____ |
| <input type="checkbox"/> 3 Hydrocele | <input type="checkbox"/> 7 Prostate | <input type="checkbox"/> 10 NORMAL |
| <input type="checkbox"/> 4 Penis discharge | <input type="checkbox"/> 8 Undescended testicle(s) | |

FEMALE GENITALIA:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> 1 Vulva | <input type="checkbox"/> 4 Cystocele Rectocele | <input type="checkbox"/> 7 Pap |
| <input type="checkbox"/> 2 Cervix | <input type="checkbox"/> 5 Adnexae | Date _____ |
| <input type="checkbox"/> 3 Discharge | <input type="checkbox"/> 6 Uterus Size | <input type="checkbox"/> 8 Other _____ |
| | Conf. & Position | <input type="checkbox"/> 9 NORMAL |

ANAL, RECTAL

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> 1 Stool | <input type="checkbox"/> 3 Fissures/Fistual | <input type="checkbox"/> 5 Hemorrhoids |
| <input type="checkbox"/> 2 Abscesses | <input type="checkbox"/> 4 Surface Lesions | <input type="checkbox"/> 6 NORMAL |



NEUROLOGICAL (check abnormalities/dysfunctions)

- | | |
|--|---|
| 1. <input type="checkbox"/> 1 Impaired mental status | <input type="checkbox"/> 20 Deviation |
| <input type="checkbox"/> 2 C.N.V. | <input type="checkbox"/> 21 Fasciculation |
| <input type="checkbox"/> 3 Clinch teeth | <input type="checkbox"/> 22 Incoordination |
| <input type="checkbox"/> 4 Corneal reflex | <input type="checkbox"/> 23 Finger to nose |
| <input type="checkbox"/> 5 Blinking | <input type="checkbox"/> 24 Rapid hand flops |
| <input type="checkbox"/> 6 Impaired speech | <input type="checkbox"/> 25 Rapid foot pat |
| <input type="checkbox"/> 7 C.N. XI | <input type="checkbox"/> 26 Finger to thumb in sequence |
| <input type="checkbox"/> 8 Shoulder shrug | |
| <input type="checkbox"/> 9 Head movements against pressure | |
|
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 |
| <input type="checkbox"/> 10 C.N. VII | <input type="checkbox"/> 27 Cerebellar dysfunction |
| <input type="checkbox"/> 11 Raise eyebrows | <input type="checkbox"/> 28 Hop on one foot in place |
| <input type="checkbox"/> 12 Frown | <input type="checkbox"/> 29 Shallow knee bend 1 at a time |
| <input type="checkbox"/> 13 Clinch eyes and don't allow to be opened | <input type="checkbox"/> 30 Walk on toes |
| <input type="checkbox"/> 14 Show teeth | <input type="checkbox"/> 31 Walk on heels |
| <input type="checkbox"/> 15 Smile | <input type="checkbox"/> 32 Tremor |
| <input type="checkbox"/> 16 Puff cheeks | <input type="checkbox"/> 33 Impaired sense of touch (sharp & blunt testing) |
| <input type="checkbox"/> 17 Tighten platysma | <input type="checkbox"/> 34 Impaired stereognostic discrimination |
|
 |
 |
| <input type="checkbox"/> 18 C.N. XII | <input type="checkbox"/> 35 Other _____ |
| <input type="checkbox"/> 19 Stick out tongue | <input type="checkbox"/> 36 NORMAL |

2. Reflexes (check if diminished or absent)

- | | | |
|--|--|--|
| <input type="checkbox"/> 1 Biceps | <input type="checkbox"/> 4 Soleus (achilles) | <input type="checkbox"/> 7 Other _____ |
| <input type="checkbox"/> 2 Quadriceps (patellar) | <input type="checkbox"/> 5 Babinski | <input type="checkbox"/> 8 NORMAL |
| <input type="checkbox"/> 3 Triceps | <input type="checkbox"/> 6 Hoffman's | |

MUSCULOSKELETAL Osteopathic 10 Step Screening

(check difficulties/abnormalities)

- | | | |
|---|--|---|
| <input type="checkbox"/> 1 Gait and posture | <input type="checkbox"/> 4 Seated Flexion | <input type="checkbox"/> 7 Seated Lateral Flexion |
| <input type="checkbox"/> 2 Standing Lateral Flexion | <input type="checkbox"/> 5 Seated Cervical | |
| <input type="checkbox"/> 3 Standing Flexion | <input type="checkbox"/> 6 Seated Trunk Rotation | |

8. Upper Extremity Testing:

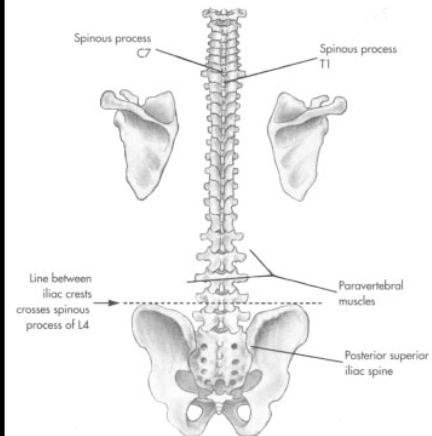
	1	2	3	4	5
	R.O.M.	Weakness	Asymmetry	Inflammation	Normal
<input type="checkbox"/> 1 Neck	_____	_____	_____	_____	_____
<input type="checkbox"/> 2 Shoulders	_____	_____	_____	_____	_____
<input type="checkbox"/> 3 Elbows	_____	_____	_____	_____	_____
<input type="checkbox"/> 4 Wrists	_____	_____	_____	_____	_____
<input type="checkbox"/> 5 Hands	_____	_____	_____	_____	_____
<input type="checkbox"/> 6 Fingers	_____	_____	_____	_____	_____
<input type="checkbox"/> 7 Other _____	_____	_____	_____	_____	_____

9. Back and Ribs:

- | | | |
|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> 1 Asymmetry | <input type="checkbox"/> 3 Restriction | <input type="checkbox"/> 5 NORMAL |
| <input type="checkbox"/> 2 Scoliosis | <input type="checkbox"/> 4 Other _____ | |

10. Lower Extremity Testing:

	1	2	3	4	5
	R.O.M.	Weakness	Asymmetry	Inflammation	Normal
<input type="checkbox"/> 1 Hips	_____	_____	_____	_____	_____
<input type="checkbox"/> 2 Legs	_____	_____	_____	_____	_____
<input type="checkbox"/> 3 Knees	_____	_____	_____	_____	_____
<input type="checkbox"/> 4 Ankles	_____	_____	_____	_____	_____
<input type="checkbox"/> 5 Feet	_____	_____	_____	_____	_____
<input type="checkbox"/> 6 Other _____	_____	_____	_____	_____	_____



Signature of Examining Physician