

Medical

Name: _____ Date: _____

Age: _____ Sex: _____ Ht: _____ Wt: _____

Blood Pressure: _____ Pulse: _____ Temp: _____

Eyes: _____ Ears: _____ Nose: _____ Throat: _____

Heart: _____ Lungs: _____

Abdomen: _____ Genitalia: _____ Rectal: _____

Extremities: _____

Neurological: _____

Impression: _____

Recommendations: _____

Signature of Examining Physician: _____

Address: _____