

Significant Medical Conditions (✓)

	Yes	No	If Yes, Explain
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	
Neuromuscular Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic Condition.....	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Illness.....	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify).....	<input type="checkbox"/>	<input type="checkbox"/>	

Report of Physical Examination (✓)

	Normal	Abnormal	If Abnormal, Explain
● Height (inches)			
● Weight (pounds)			
● Pulse ()			
● Blood Pressure /			
● Hair/Scalp			
● Skin			
● Eyes — Visual Acuity R___/___ L___/___			
● Eyes — Color Vision			
● Ears — Hearing dB R L			
● Nose and Throat			
● Teeth and Gingiva			
● Lymph Glands			
● Heart — Murmur, etc.			
● Lung — Adventitious Findings			
● Abdomen			
● Genitalia			
● Neuromuscular System			
● Extremities			
● Spine (Presence of Scoliosis)			

Date of Examination

Signature of Examiner

Print Name of Examiner

Address