HF MEDICAL ASSOCIATES, P.A.

NAME ______________________________

INITIAL PHYSICAL EXAM

DATE: ___/___/___

BP ________ P ________ HT ________ WT ________ TEMP ________ Taken by ________

General ______________________________

Heent ______________________________

Neck ______________________________

Chest & Lungs ______________________________

Breasts ______________________________

Heart ______________________________

G/U ______________________________

Abdomen ______________________________

Pelvic Inspection ______________________________

BI*Manual ____________________ Specular ____________

Rectal ______________________________

Extremities ____________________ Prostate ____________

Skin ______________________________

Neurological ______________________________

Impression - ______________________________

____________________ Meds ____________

- ______________________________

- ______________________________

Plan ______________________________

X-Ray ______________________________

Transvaginal/Pelvic Sono/Bilateral Mammogram/Breast Sono ____________

Thin PAP/Regular PAP/Chlamydia&CC ____________

CBC/CMP/LIPID/UA/TSH/LH/FSH/ESTRADIOL/UC&S/OTHER ____________

Exercise ____________ Diet ____________ Immunization ____________

Referral ______________________________

Return to Clinic ________ days ________ weeks ________ months ________ routine ________

Henriete Faillace