



ADULT COMPLETE PHYSICAL EXAMINATION 45-50 YEARS

Date _____	Patient Name _____	DOB _____
Allergies _____		Medications _____
Illness/Accidents/Problems/Concerns since last visit: _____ _____		
<p style="text-align: center;">History (check if discussed)</p> <p><input type="checkbox"/> Family _____</p> <p><input type="checkbox"/> Medical _____</p> <p>Risk Evaluation</p> <p><input type="checkbox"/> Nutrition</p> <p><input type="checkbox"/> Physical activity</p> <p><input type="checkbox"/> STD/HIV</p> <p><input type="checkbox"/> Sexual behavior</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Problems/concerns</p> <p>Substance Abuse</p> <p><input type="checkbox"/> Tobacco _____</p> <p><input type="checkbox"/> Alcohol _____</p> <p><input type="checkbox"/> Drugs _____</p> <p>Immunizations</p> <p><input type="checkbox"/> UTD</p> <p><input type="checkbox"/> Needed</p>	<p style="text-align: center;">Physical Exam (check = WNL, X = ABN describe abnormal findings)</p> <p>Temp _____ Pulse _____</p> <p>Resp _____ BP _____</p> <p>Ht. _____ ft. _____ in.</p> <p>Wt. _____ lbs. _____ oz.</p> <p><input type="checkbox"/> Appearance _____</p> <p><input type="checkbox"/> Skin/nodes _____</p> <p><input type="checkbox"/> Head _____</p> <p><input type="checkbox"/> Eyes _____</p> <p><input type="checkbox"/> Ears _____</p> <p><input type="checkbox"/> Nose _____</p> <p><input type="checkbox"/> Mouth _____</p> <p><input type="checkbox"/> Teeth _____</p> <p><input type="checkbox"/> Gums/Palate _____</p> <p><input type="checkbox"/> Neck _____</p> <p><input type="checkbox"/> Chest _____</p> <p><input type="checkbox"/> Breast _____</p> <p><input type="checkbox"/> Lungs _____</p> <p><input type="checkbox"/> Heart _____</p> <p><input type="checkbox"/> Abdomen _____</p> <p><input type="checkbox"/> Testicular Exam _____</p> <p><input type="checkbox"/> Prostate Exam _____</p> <p><input type="checkbox"/> DRE (male/female) _____</p> <p><input type="checkbox"/> Pelvic _____</p> <p><input type="checkbox"/> Extremities/hips _____</p> <p><input type="checkbox"/> Spine _____</p> <p><input type="checkbox"/> Neurological _____</p> <p>Comments: _____</p> <p>Signature _____</p>	<p style="text-align: center;">Health Education (check if discussed)</p> <p>Safety/Violence</p> <p><input type="checkbox"/> Seatbelts 100%</p> <p><input type="checkbox"/> Sports equipment</p> <p><input type="checkbox"/> Alcohol/drugs/weapons</p> <p><input type="checkbox"/> Emotional, physical and sexual abuse</p> <p>Counseling</p> <p><input type="checkbox"/> Folic acid supplementation</p> <p><input type="checkbox"/> Menopause and HRT</p> <p><input type="checkbox"/> Testicular self-exam</p> <p><input type="checkbox"/> Breast self-exam</p> <p>Handouts</p> <p>Plan</p> <p><input type="checkbox"/> Pap every 1-3 years</p> <p><input type="checkbox"/> Lipid profile every 5 years</p> <p><input type="checkbox"/> Vision and Glaucoma screening every 2 years</p> <p><input type="checkbox"/> Blood glucose tolerance</p> <p><input type="checkbox"/> Mammography every 1-2 years</p> <p>Diagnosis _____</p> <p>Return to office _____</p>