

## **PHYSICAL EXAMINATION FORM**

### Country Roads Program

**\*\*To be completed by a medical doctor or advanced care physician (NP/PA)**

Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_  
 Vision: R20/ \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal Unequal

| MEDICAL               | Normal (Check) | Abnormal Findings (Please Specify) | Initials/Date |
|-----------------------|----------------|------------------------------------|---------------|
| Appearance            |                |                                    |               |
| Eyes/Ears/Nose/Throat |                |                                    |               |
| Hearing               |                |                                    |               |
| Lymph Nodes           |                |                                    |               |
| Heart Murmur          |                |                                    |               |
| Pulse                 |                |                                    |               |
| Lungs                 |                |                                    |               |
| Abdomen               |                |                                    |               |
| Genitourinary (males) |                |                                    |               |
| Skin                  |                |                                    |               |
| Musculoskeletal       |                |                                    |               |
| Neck                  |                |                                    |               |
| Back                  |                |                                    |               |
| Shoulder/Arm          |                |                                    |               |
| Elbow/Forearm         |                |                                    |               |
| Wrist/Hands/Fingers   |                |                                    |               |
| Hip/Thigh             |                |                                    |               |
| Knee                  |                |                                    |               |
| Leg/Ankle             |                |                                    |               |
| Foot/Toes             |                |                                    |               |

Cleared without restriction: \_\_\_\_\_ Date \_\_\_\_\_

Not Cleared: \_\_\_\_\_ Cleared with specific restrictions (list) \_\_\_\_\_

Cleared with recommendations for further evaluation or treatment for: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_ Date: \_\_\_\_\_

**Print Name and Address of Physician completing this form:**

Name: \_\_\_\_\_ Address \_\_\_\_\_