



# PHYSICAL EXAMINATION FORM

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_

Vision \_\_\_\_\_ L20/ \_\_\_\_\_ Corrected: Y N

			Normal	Abnormal Findings	
		COMPLETE	LIMITED	Cardiovascular	
Pulses					
Heart					
Lungs					
Skin					
E.N.T					
Genitalia (males)					
Musculoskeletal					
Neck					
Shoulder					
Elbow					
Wrist					
Hand					
Back					
Knee					
Ankle					
Foot					
Other					

Clearance:

- A. Cleared
- B. Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_
- C. Not Cleared for:

- Collision
- Contact
- Noncontact     Strenuous     Moderately Strenuous     Nonstrenuous

Due Date: \_\_\_\_\_

Recommendation: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Physician \_\_\_\_\_ M.D. or D.O.