



Physical Examination

Patient Name _____ Birth Date _____

Height _____ Weight _____ Heart Rate _____ BP _____ / _____ Resp. Rate _____

	Normal	Abnormal Findings
Medical		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Heart (Rate and Rhythm)		
Thyroid		
Lungs		
Abdomen		
Skin		
Neurological		
Muscoskeletal		
Deep Tendon Reflexes		
Upper Extremities strength and tone		
Lower Extremities strength and tone		

Assessment

General Health Assessment: Excellent Good Fair Poor

Recommendations:

I certify that I have on this date examined this patient and that, on the basis of the examination requested by SanTan Natural Medicine and this patient's medical history as furnished to me, I have found no serious pre-existing medical conditions. **(Note exceptions above).**

Physician's Name and Address (Stamp or Print)

If the Physician's Assistant (P.A.) or Advanced Nurse Practitioner (A.P.N.) performed the exam, name and address of collaborating physician or physician's group:

Examiner's Signature **Date**

Examiner's Telephone Number

Please return by fax to: **480.452.1625**