Initial Exam / Follow up

Name: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **BMI**_____ **Pulse:** _____ **BP:** _____

History			
Chief Complaint			
Medical	**Normal**	**Abnormal Findings**	**Initials***
Heart*			
Lungs*			
Abdomen*			
Ankles /Edema*			
Foot			
Appearance			
Skin			
Eyes/Ears/Nose			
Throat/ Oropharynx			
Lymph Nodes			
Pulses			
Neck			
Back			
Shoulder/Arm			
Elbow/ Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			

All bold and * must be completed in both intial and follow up visit

Medically Cleared: YES_____ NO ___

Name of physician (print/type) _____ **Date** _____

Address _____ **Phone** _____

Signature of physician _____ **MD/DO/NP/PA-C**

FAX COMPLETED FORM TO: 866-624-7650 _____