QUADRANT

PHYSICAL EXAMINATION FORM

Patient Name: DOB:

Vital Signs

Height	Weight	Temp
in	lbs	F

B/P	P	Resp

Medications

_____
_____
_____
_____
_____

Allergies:
_____
_____
_____
_____

U/A Dip

SEE ATTACHED CLINITEK PRINTOUT

SpGr	Prot	Heme	Gluc

pH	Leuk	Nit

Urob	Keto	Bili

☐ Comments: _____

Vision

☐Corrected ☐ Uncorrected

Far		Near	
Both	20/	Both	20/
Right	20/	Right	20/
Left	20/	Left	20/

Color	Peripheral			
_/ # plates	R		L	

☐ Comments: _____

Whisper:	R ft	L ft

Examination

Exam	Normal	N/E	Abnormal Findings
General			
Skin			
HEENT			
Neck			
Chest			
Lungs			
Heart			
Abdomen			
Upper Extremities			
Lower Extremities			
Spine / Back			
Neurological			

History and Physical Summary

☐ Medically Cleared
☐ Not medically cleared *Unable to perform essential job functions with or without accommodation.*
☐ Restricted *Needs restrictions or accommodations:* _____
_____
☐ Medical hold *Final opinion and recommendation deferred until additional information is available.* Comments: _____
_____

Recommendations and Patient Education

The employee / applicant was informed that today's examination does not replace a routine annual exam and episodic care with a primary care provider. The outcome of this examination and the following health promotion material was provided and reviewed with the employee / applicant:

☐ Follow up with your Primary Care Physician (PCP) for evaluation of: _____
☐ Obtain records from your PCP for further evaluation.
☐ Schedule annual physical exams with your PCP.

☐ Diet & Exercise
☐ Cholesterol
☐ Vision Exams
☐ Hearing Exams
☐ Prostate health
☐ Smoking Cessation
☐ GYN evaluation
☐ Dental examination
☐ Immunizations
☐ Wear safety belts
☐ HTN
☐ Diabetes
☐ Back safety / Ergonomics on job
☐ ID prevention
☐ Other: _____

Examiners Signature: _____ MD, NP, PA Date: _____
Examiner Name – Print: _____
Comments: _____
_____