Medical Examination Form

Community Counseling Services

Rev 01/17

Case Id# _____

Case Name _____

Date _____

Program _____Physician_____

Address _____Phone_____

Date of Examination ____/____/_____ Patient Name_____

Date of Birth ____/____/_____ Age_____ Sex___ Race _____

General Appearance_____ Temperature_____

Weight_____Height_____Blood Pressure_____Pulse_____ Head Circumference_____

Current Medications _____

Describe Any Special Diet Required_____

Check	Normal	Abnormal	Remarks
1. Head			
2. Fontanelle			
3. Skin			
4. Lymph Nodes			
5. Facies			
6. Eyes a. Right			
b. Left			
7. Ears a. Right			
b. Left			
8. Nose			
9. Mouth			
10. Teeth and Gums			
11. Tongue			
12. Pharynx & Palate			
13. Neck			
14. Thorax			
15. Heart			
16. Lungs			
17. Abdomen			
18. Breasts			
19. Genitals			
20. Spine			
21. Extremities			
22. Neurological:			
a. Cranial			
b. Reflexes			
c. Neuromuscular			
d. Stand and Gait			
e. Mood/ Behavior			
23. Urine			
24. CBC			

Is patient physically able to participate in services? ☐ Yes ☐ No Patient free of communicable disease/condition? ☐ Yes ☐ No

Based upon the results of this examination and the additional information provided, this person is sufficiently free from disease and does not have any health conditions that would create a hazard for other people.

_____ _____

Signature of Healthcare Provider Date