

## Pre-Placement Physical Exam

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

I.D. Presented: \_\_\_\_\_

Height: \_\_\_\_ ft. \_\_\_\_ in.

Weight: \_\_\_\_\_ lb.

Resting Heart Rate: \_\_\_\_\_ Blood Pressure: \_\_\_\_ Normal \_\_\_\_ Elevated Highest Reading \_\_\_\_/\_\_\_\_

### Physical Readings

General Appearance: \_\_\_\_ Normal \_\_\_\_ Abnormal

HEENT: \_\_\_\_ Normal \_\_\_\_ Abnormal

Lymph Nodes: \_\_\_\_ Normal \_\_\_\_ Abnormal

Chest: \_\_\_\_ Normal \_\_\_\_ Abnormal

Breast: \_\_\_\_ Normal \_\_\_\_ Abnormal

Lungs: \_\_\_\_ Normal \_\_\_\_ Abnormal

Heart: \_\_\_\_ Normal \_\_\_\_ Abnormal

Abdomen: \_\_\_\_ Normal \_\_\_\_ Abnormal

Genitalia \_\_\_\_ Normal \_\_\_\_ Abnormal

Testes \_\_\_\_ Normal \_\_\_\_ Abnormal

Spine \_\_\_\_ Normal \_\_\_\_ Abnormal

Extremities \_\_\_\_ Normal \_\_\_\_ Abnormal

Neurological \_\_\_\_ Normal \_\_\_\_ Abnormal

Skin \_\_\_\_ Normal \_\_\_\_ Abnormal

\*If abnormal please verify findings here:

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Exam Results: \_\_\_\_ Normal \_\_\_\_ Abnormal\*

Date of Exam: \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year

Examiner's Signature: \_\_\_\_\_

Examiner's Printed Name: \_\_\_\_\_

Examiner's Address: \_\_\_\_\_

Examiner's Phone: \_\_\_\_\_