Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

HealthWorks
A Service of Lehigh Valley Physician Group

PHYSICAL EXAMINATION

Name_____Date_____

Height_____ Weight_____

Vision with/without correction Far RT_____ LT_____ Both_____

Safety glasses ❑Yes ❑ No Near RT_____ LT_____Both_____

Color_____

Depth Perception_____%

Peripheral RT_____ LT_____

Hearing: Whisper RT_____Feet LT_____Feet
❑ See Audiogram

Blood Pressure_____ Repeat_____

Pulse_____

Urine Dip: Sugar_____ Specific Gravity_____ PH_____ Blood_____ Protein_____

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
Skin				Lungs			
Head				Heart			
Eyes				Abdomen			
Ears				Genitourinary			
Nose				Back			
Throat				Extremities			
Teeth				Nervous System			
Neck							

Findings/Recommendations: Follow-up with personal health care provider for preventative, routine, and on-going evaluation and care.

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_____

Medical Examiner (Print)_____**Signature** _____

Date & Time_____