DOCTOR EXAM FORM

DATE OF EXAM: ____________________ PATIENT NAME: ____________________________________

ADDRESS: ____

CITY: _______________________________ STATE: ____________ ZIP: _________________

PHONE: (_______) _______ - __________

DATE OF BIRTH: _____/_____/_________ AGE: _______________ SEX: M F

BLOOD PRESSURE: _____________________ WEIGHT: ____________ HEIGHT: _____________

Physical Exam	Normal	Abnormal
General	☐	☐
HEENT	☐	☐
Neck	☐	☐
Chest	☐	☐
Cor	☐	☐
Abdomen	☐	☐

IMPRESSION: ____

ALLERGIES (including medication): ____

CURRENT OTC MEDICATION: ____
(Name, Strength and Dosage)

PHYSICIAN SIGNATURE: ____ DATE: _________________

PHYSICIAN NAME: ____________________________________ PHONE: (______) ______ - ___________

ADDRESS: ____

REQUIRED LABORATORY RESULTS:

- ☐ Complete Blood Count, DIFF, PLTS
- ☐ Comprehensive Metabolic Screen
- ☐ Comprehensive Lipid Panel
- ☐ Thyroid Profile (TSH, T3U, T4)