## Routine Exam Form

Name: ____________________ Date: ____________________

ISN: ____________________ DOB: ________________ AGE: ___________

Chief Complaint:

HPI:

PMH:

MEDS:

Allergies:

Physical Exam:

| VS: | BP | P | R | $SaO_2$ | Weight |
|---|---|---|---|---|---|

HEENT: Normal / Abnormal
CV: Normal / Abnormal
PULM: Normal / Abnormal
GI: Normal / Abnormal
GU: Normal / Abnormal
OB/GYN: Normal / Abnormal / NA
MS: Normal / Abnormal
NEURO: Normal / Abnormal
DERM: Normal / Abnormal
ENDO: Normal / Abnormal
PSYCH: Normal / Abnormal

Comments / Findings:

Impression: ____________________________________________

____________________________________________

Disposition: ____________________________________________

____________________________________________

Provider Signature: Printed Name / Stamp:

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