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Name ***Telephone Number***

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If you ____ have had or now have any of the following, check yes, if not please check no.

Epilepsy	☐	☐	Wear Glasses/Contact Lenses	☐	☐
Diabetes	☐	☐	Ear Trouble	☐	☐
High Blood Pressure		☐	Heart Problems	☐	☐
Eating Disorder	☐	☐	Pain or Pressure in Chest	☐	☐
Measles	☐	☐	Palpitations or Pounding of Heart	☐	☐
German Measles	☐	☐	Cancer	☐	☐
Mumps	☐	☐	Frequent Indigestion	☐	☐
Chicken Pox	☐	☐	Sugar or Albumin in Urine	☐	☐
Scarlet Fever	☐	☐	Insomnia	☐	☐
Whooping Cough	☐	☐	Nervousness, Tension, Anxiety	☐	☐
Rheumatic Fever	☐	☐			

☐

☐ ☐

(This side to be completed by examining physician)

Height _____ **Build** _____ **Blood Pressure** _____

Weight _____ **Pulse** _____ **Hearing: Right** _____

Left _____

Vision: Right 20/ _____ **Corrected to 20/** _____ **by contacts** _____

Left 20/ _____ **Corrected to 20/** _____ **by glasses** _____

CLINICAL EVALUATION

Check each item in proper column	**NORMAL**	**ABNORMAL**	**GIVE DETAILS OF EACH ABNORMALITY & IDENTIFY BY NO.**
1. Head, Neck, Face and Scalp			
2. Nose and Sinuses			
3. Throat			
4. Oral Cavity			
5. Ears *(perforation or drum, etc.)*			
6. Eyes *(lids, conjunctiva, color blindness, etc.)*			
7. Pupils and ocular motion			
8. Lungs, chest, and breasts			
9. Heart *(include estimate of cardiac function)*			
10. Vascular system *(varicosities, etc.)*			
11. Abdomen and viscera *(include hernia/other disorders)*			
12. Ano-rectal *(pilonidal cyst)*			
13. Endocrine system			
14. G-U system			
15. Upper extremities *(strength/movement)*			
16. Feet			
17. Lower extremities *(as for uppers)*			
18. Spine, other musculo-skeletal			
19. Skin and lymphatics			
20			