CLINTON JUNIOR COLLEGE

PHYSICAL EXAMINATION FORM

NAME ________________________________ DATE of BIRTH ______________________

AGE________________ GENDER_______F______M DATE OF EXAM_______________

HEIGHT________ WEIGHT ________ BP________ PULSE:________

VISION: ®_________ (L)_________ (B)_______

COLOR VISION: NORMAL________ RED GREEN DEFICIENCY______

TOTAL COLOR BLINDNESS ___________

	NORMAL	ABNORMAL	REMARKS
HEAD & NECK			
EYES			
EARS			
NOSE			
MOUTH & THROAT			
TEETH & GUMS			
THYROID			
CHEST & LUNGS			
BREAST			
HEART			
ABDOMEN			
UPPER EXTREMITIES			
LOWER EXTREMITIES			
NEUROLOGIC			
CERVIAL SPINE			
THORACIC SPINE			
LUMBER SPINE			
GENITALIA			
RECTUM			
SKIN			
POSTURE			
ALIGNMENT			
MOBILITY			

SUMMARY OF FINDINGS____

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RECOMMENDATIONS____

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SIGNATURE OF MEDICAL PROFESSIONAL ____________________________________