New Patient Physical Assessment Form

Patient Details:

Full Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Phone Number: _____

Medical History:

Chronic Illnesses: _____

Current Medications: _____

Allergies: _____

Surgical History: _____

Physical Examination:

Height: _____

Weight: _____

BMI: _____

Blood Pressure: _____

Heart Rate: _____

System Check (Table):

System	Normal	Abnormal	Notes
Head & Neck	[ ]	[ ]	
Chest & Lungs	[ ]	[ ]	
Heart	[ ]	[ ]	
Abdomen	[ ]	[ ]	

Extremities	**[ ]**	**[ ]**	
Skin	**[ ]**	**[ ]**	
Neurological	**[ ]**	**[ ]**	
Psychological	**[ ]**	**[ ]**	

Doctor's Comments:

Observations: _____

Recommendations: _____

Doctor's Name: _____

Date: _____