

Physical Examination

El Paso County Department of Human Services
P.O. Box 2692
Colorado Springs, Colorado 80901

County Case No. _____ Suffix _____

Name _____ Sex _____ Date of Birth _____

Date of Examination _____

NOTE: If more space is needed, please use back side of this sheet.

Height _____ Weight _____ Temperature _____

Skin _____

Scalp _____

Eyes - Papillary Reaction _____ Vision without glasses Right _____ Left _____

Vision with glasses Right _____ Left _____

Ears - Ooscopic _____ Hearing Right _____ Left _____

Nose _____

Teeth - Number _____ Condition _____ Occlusion _____

Throat - Pharynx _____ Tonsils _____

Adenoids _____ Glands _____

Thyroid _____ Chest _____

Heart _____ Lungs _____

Abdomen _____

Secondary Sex Characteristics _____ Genitals _____

Reflexes _____ Extremities _____

Posture and Spine _____

Nutrition _____

Signs of Endocrine Imbalance _____

Menses _____

Blood Pressure: (1) Normal _____ (2) Abnormal _____ (3) Vasomotor Stability _____

Treatment given: _____

Recommendations: _____

Examining physician's signature _____

Please print or type Physician's name, complete address and phone number
