

Center Participant # Participant Initials Week Sequence 0 1

Date / / Staff ID

mo. da. yr.

PHYSICAL CHECKUP

Examination	Normal	Abnormal	Not Examined	Explanation of Abnormalities
9. Skin/Mucosae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Neck/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Chest/Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Liver (include palpation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If liver is enlarged, number of cm below right costal margin: <input type="text"/> <input type="text"/> <input type="text"/>
18. Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Genitalia/Rectal (examined only if clinically indicated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
a. Mental status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Cranial Nerves II-XII	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. Strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Cerebellar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Gait & Station	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. ECG (if clinically indicated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Other, specify:	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Signature _____