PO'AILANI, INC.
CONTINUUM OF CARE

Physical Examination Record

Name: _____ Date of Birth: _____

Address: _____
Street Number City Island Zip Code

Height: _____ Weight: _____ B/P: _____

TB Clearance:
Chest x-ray _____ Mantoux: _____ Results: _____

Hgb _____ Hct. _____ UA _____

Others _____

Eyes _____ Pupils _____ Ears _____

Vision/rt. _____ Vision/lt. _____

Corrected Vision/rt. _____ Corrected Vision/lt. _____

Hearing/rt. _____ Hearing/lt. _____

Nose _____ Thyroid _____ Mouth _____

Teeth _____ Heart Rate _____ Rhythm _____

Murmurs _____ Abdomen _____ Lungs _____

Kidneys _____ Hernia _____ Skin _____

Genitalia/Pelvis _____ Hemorrhoids _____ Reflexes _____

Varicosities _____ Romberg _____

Extremities
Upper _____ Lower _____

Other Abnormalities _____
Current Medications _____
Diagnosis _____
Diet _____

Physician's Name _____

Physician's Signature _____ Date: _____