

# Physical Exam Form

## Appointment Information

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_ am/pm

## Patient Information

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Drivers License No.: \_\_\_\_\_

State Issued: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Physician Information

1. Name of Personal Physician (If none, record "None"): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Date last consulted: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_

3. What treatment or medication was given or recommended: \_\_\_\_\_

\_\_\_\_\_

## Physical Measurements

1. Height: \_\_\_\_\_ ft. \_\_\_\_\_ inches

2. Weight: \_\_\_\_\_ lbs

3. Chest at inspiration: \_\_\_\_\_ inches

Chest at expiration: \_\_\_\_\_ inches

4. Umbilicus: \_\_\_\_\_ inches

5. Pulse: \_\_\_\_\_ bpm

Any irregularities? \_\_\_\_\_

6. Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ If above 140/90, record additional reading: \_\_\_\_\_

### Examination Questions

If the patient answers yes to any of the below questions, please provide requested details in Question #19.

Question	Yes	No	Comments
1. Have you ever had or been treated for cancer tumor?			
2. In the last ten (10) years have you had, been treated for or received counseling for:			
a. High blood pressure, chest pain, or disorder of the heart or circulatory system?			
b. Diabetes or disorder of the glands, bone, blood or skin?			
c. Complications of pregnancy, infertility or any disorder of the breasts, reproductive or genital organs, prostate, kidneys or urinary systems?			
d. Hernia, hepatitis, or disorder of the liver, gall bladder, stomach, pancreas, spleen, intestines or rectum?			
e. Arthritis, rheumatism, or disorder of the joints, limbs, or muscle?			
f. Disorder or condition of the back, neck, or spine?			
g. Allergy, asthma, sinusitis, emphysema, disorder of the lungs or respiratory system, or sleep apnea?			
h. Epilepsy, stroke, dizziness, headache, or disorder of the brain or spinal cord?			
i. Disorder of the eyes, ears, nose or throat?			
j. Anxiety, depression, nervousness, stress, mental or nervous disorder, or other emotional disorder?			
k. Chronic fatigue syndrome, fibromyalgia, Epstein barr virus or Lyme disease?			
3. Do you have any loss of hearing or sight, an amputation of any kind, or any physical deformity, impairment or handicap?			
4. Within the past ten years, have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any deficiency of the immune system such as Human immunodeficiency Virus?			
5. Medication/Drug History			
a. Are you currently taking prescription medication?			
b. Are you currently taking non-prescription medication?			
c. Have you ever regularly and repeatedly used stimulants, hallucinogens, narcotics, or any other controlled substance other than as prescribed by a physician?			
d. Have you ever had or been advised to have counseling or treatment for alcohol or drug use?			
6. Are you now pregnant? (If yes, record expected delivery date in comments)			
7. Within the past five years, have you had a sickness or injury for which you have made a benefits claim or for which you will make a benefits claim?			
8. Within the past five years, have you had a physical exam or check-up of any kind?			
9. Within the past five years, have you been advised to have a surgery or any diagnostic tests that were not performed, except for HIV tests?			
10. Other than previously stated in the past five years have you received medical advice from physicians, medical/mental health professionals, or any other practitioners, and have you been a patient in a hospital, clinic, sanatorium, or other medical facility?			
11. Do you participate in regular exercise? If yes, describe the type and frequency in the comments section.			
12. Do you smoke cigarettes, cigars, or a pipe? If yes, record how often in the comments section.			

**Examination Questions, continued**

Question		Yes	No	Comments
13. Do you have any reason to believe that you are not in good health or decreased state of well-being?				
14. Do you or any member of your family suffer from: diabetes, high blood pressure, heart disease, mental illness, or attempts of suicide?				
15. Pain Questions:				
a. Did you hurt yourself?				
b. Where did you hurt yourself?				
c. What is the degree of pain on a scale of 1-10 (10 being the most painful)?				
d. How did you hurt yourself?				
e. When did this happen?				
16. Has any doctor ever refused or recommended you not to take narcotic/pain or anxiety medications? (If yes, please explain in the comments section)				
17. Do you have any of the below symptoms associated with headaches?				
a. Blurry vision?				
b. Auras?				
c. Nausea?				
d. Vomiting?				
18. Have you ever seen a neurologist? (If yes, document the diagnosis in the comments section)				
19. Do you have a copy of any of the following reports?				
• MRI				
• Cat Scan				
• PET Scan				
• X-Ray Diagnosis				
• Operative				
• Lab Test Results				
• Progress Notes				
• Consult and treatment reports				
<b>(Please fax the ones you have to 305-402-0232)</b>				
20. Please record details of yes answers in the space below. Identify the applicable question number and provide a detailed explanation.				
Question #.	Dates from – to	Condition, Treatment, and Results	Names of Physician(s), Hospital/Facility, and addresses (city, state, zip).	
21. Please record the requested information on each relative type listed:				
Family Member	Age (if Living)	Age (if deceased)	Cause of Death	
Father				
Mother				
Brothers				

Brothers			
Brothers			
Sisters			
Sisters			
Sisters			

**Patient Statement & Signature**

I hereby represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. All notations made by the examiner shall be deemed accurate and admissible for the purpose(s) intended.

\_\_\_\_\_

(Patient First and Last Name, please print)

\_\_\_\_\_

(Patient Signature)

\_\_\_\_\_

(Date)

**Examiner Information**

I certify that I personally asked each and every question on the physical exam form and accurately recorded the answers thereon, I personally performed the physical measurements and observations recorded on this document.

Name \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Examining Company:**  
**IMS – Insurance Medical Services, inc.**  
**46540 Fremont Blvd. Suite 514**  
**Fremont, CA 94538**

