

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE NAME:** _____
DATE OF BIRTH: _____ **SS#:** _____ **GENDER:** _____

Height: _____ inches / _____ ft _____ in **Weight:** _____ lbs **Pulse:** _____ **Blood Pressure:** _____

Urinalysis: pH: _____	Specific Gravity: _____	Glucose: _____ POS _____ NEG	Blood: _____ POS _____ NEG _____ TRACE	Protein: _____ POS _____ NEG _____ TRACE
------------------------------	--------------------------------	------------------------------------------------------	--------------------------------------------------------------------------	----------------------------------------------------------------------------

Vision Screening:	Right 20/____	Left 20/____	Both 20/____	Were contacts/glasses worn?	Yes	No
Near Vision:	Right 20/____	Left 20/____	Both 20/____	Corrected:	Right 20/____	Left 20/____ Both 20/____

HEAD/NECK: _____

SHOULDERS: **Right:** _____ **Left:** _____

ELBOWS/HANDS/WRISTS: _____

LOW BACK: _____

PELVIS/HIPS: _____

KNEES: **Right:** _____ **Left:** _____

ANKLES: **Right:** _____ **Left:** _____

LOWER LEGS/FEET/TOES: _____

HEART/LUNGS: _____

GENITALIA/HERNIA (Males): _____

Physician Signature: _____ **Date:** _____