



Physical Exam

Participant Name: _____
 Date of Birth: ____/____/____ Date of Exam: _____

CLINICAL EVALUATION

Height: _____ Weight: _____ B/P: _____

Check all examined. Please enter NE if Not Evaluated

	Normal	Abnormal	Notes/Details
Vision			
Hearing			
Mouth/ Throat/ Neck			
Extremities (strength, ROM, etc.)			
Cardiovascular System			
Heart			
Respiratory System			
Gastrointestinal System			
Skin			
Spine/ Other Musculo-skeletal			
Endocrin			
Reflexes			
Coordination			
Psychiatric			
Neurological			

Current Medical Conditions & Related Treatment:

Any other issues or concerns that MICC should be aware of?: _____

IMMUNIZATION RECORD

Immunization	Dates <i>Month/day/year</i>	Notes:
Diphtheria/ Tetanus		Must be within last 10 years
Measles		Must be after age 12 months
Mumps		Must be after age 12 months
Rubella		Must be after age 12 months
MMR Combined Vaccine		Or separate above
Other		

Examining Health Care Provider Name (Please Print): _____
 Signature: _____ Date: _____