



RESIDENT PHYSICAL EXAMINATION RECORD

Name: _____ Birth Date: _____

Address _____
Number Street Name City Island Zip Code

Height: _____ Weight: _____ Ears: _____

Eyes: _____ Pupils: _____ Ears: _____

VISION: Right: _____ CORRECT VISION: Right: _____ HEARING: Right: _____
Left: _____ Left: _____ Left: _____

Nose: _____ Mouth: _____ Teeth: _____ Thyroid: _____

HEART: Rate: _____ Rhythm: _____ Murmurs: _____

Lungs: _____ Nervous System: _____

Abdomen: _____ Kidneys: _____

Genitalia/Pelvis: _____ Hemorrhoids: _____

Varicosities: _____ Hernia: _____

Skin: _____ Romberg: _____ Reflexes: _____

Extremities: Upper: _____ Lower: _____

Other abnormalities: _____

Current medications, if any: _____

Resident is ambulatory and capable of following directions and taking appropriate action for self preservation under emergency conditions: Yes No

Diagnosis: _____

Diet: _____

Level of Care Assessment:

The Resident is certified as: Independent ARCH ICF SNF

Print or type physician's name Physician's Signature Date