DIAGNOSTIC IMAGING CENTERS, P.A.
Health & Wellmobile™
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PHYSICAL EXAMINATION FORM

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

Sex: ☐Male ☐Female

DIAGNOSES/SIGNIFICANT HEALTH CONDITIONS

CURRENT MEDICATIONS *(Attach a second page if needed):*

Medication Name	Dose	Frequency	Diagnosis	Prescribing Physician Specialty	Date Medication Prescribed

Allergies/Sensitivities: _____

IMMUNIZATIONS:

Tetanus/Diphtheria *(every 10 years):* _____/_____/_____

Flu Shot: _____/_____/_____ **Pneumonia Vaccine:** _____/_____/_____

Other *(specify)* _____

OTHER MEDICAL/LAB/DIAGNOSTIC TESTS:

GYN exam w/PAP: **Date:** _____ **Results:** _____
(women over age 18)

Mammogram: **Date:** _____ **Results:** _____
(every 2 years- women ages 40-19, yearly for women 50 and over)

Prostate Exam: **Date:** _____ **Results:** _____
(digital method-males 40 and over)

PSA **Date:** _____ **Results:** _____

Other *(specify)* _____ **Date:** _____ **Results:** _____

_____

Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure: _____/_____ **Pulse:** _____ **Temp:** _____ **Height:** _____ **Weight:** _____ **BMI:** _____

Vision Screening: Left _____ **Right**_____ **Corrected: yes** ☐ **no** ☐

Hearing Screening: Pass ☐ **Refer** ☐

EVALUATION OF SYSTEMS

System Name	Normal findings?	Comments/Description
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Mouth/Throat	☐ Yes ☐ No	
Head/Face/Neck	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Endocrine	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	
Integumentary	☐ Yes ☐ No	
Lymphatic	☐ Yes ☐ No	
Nervous System	☐ Yes ☐ No	

_____ _____ _____

Name of physician *(please print)* **Physician's Signature** **Date**

Physician Address: _____

Physician Phone Number: _____