## EXCEPTIONAL FAMILY MEMBER PROGRAM PHYSICAL EXAM FORM

AGE	HEIGHT	WEIGHT	BP	PULSE	TEMP	
PAST MED	ICAL HISTORY					
<ol> <li>Hospitali</li> <li>Surgery</li> <li>Chronic I</li> <li>Contacts/</li> <li>Dental A</li> <li>Medication</li> </ol>	llnesses Glasses ppliances	<ul> <li>7. Asthma</li> <li>8. Medical Allergie</li> <li>9. Headaches</li> <li>10. Menarche</li></ul>		12. Family F Sudden Dear Early Heart I Elevated Ch Other Famil	<u>YES</u> th Disease olesterol_	<u>NO</u>
PHYSICAL	EXAM					
General Bui	ld		Impression	<u>1</u>		
HEENT			5			
Lungs						
Heart					-	
Chest	<del>.</del>					
Liver						
Spleen				ž.		
Spine			<u>Plan</u>			
Neuro						
Genitalia						
Skin			,			
Extremities						
Physician S	ignature & Title				Date:	
Patient Name:						
Address:						