

EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP) PHYSICAL EXAM FORM

Patient Name: _____ DOB: _____

Age _____ HT _____ WT _____ BP _____ PULSE _____ TEMP _____

Past Medical History: PLEASE CIRCLE ANY THAT APPLY

- | | | |
|----------------------|---------------------------|-------------------------|
| 1. Hospitalization | 7. Asthma | 12. Family History |
| 2. Surgery | 8. Allergies | Sudden Death Y/N |
| 3. Chronic Illness | 9. Headaches | Early Heart Disease Y/N |
| 4. Contacts/Glasses | 10. Menarche LMP | Evel Cholesterol Y/N |
| 5. Dental Appliances | 11. Loss of consciousness | Other Family HX |

PHYSICAL EXAM

IMPRESSION

GENERAL BUILD

HEENT

NECK

LUNGS

HEART

CHEST

LIVER

SPLEEN

SPINE

NEURO

GENITALIA

SKIN

EXTREMITIES

DATE: _____

(Physician) Printed Name/Signature

(Include Address & Phone Number)