TRIAGE

Physical Form

Patient Name:_______________________________________

Date of Service:________________________

Patient Information							
Date of Birth:		Age:		Allergies:			
Height:		Weight:		Blood Pressure:		Pulse:	

Physical Exam			
Head:		Carotids:	
Eyes:	Circle One: Snellen Eye Exam Titmus Vision Test	Skin:	
Ears:		Heart:	
Nose:		Lungs:	
Throat:		Abdomen:	
Thyroid:		Extremities:	
Nodes:		Other:	

I have examined the above-named individual and find them to be in good physical and mental health, free of communicable diseases, and able to perform their essential job functions without limitations or restrictions.

____ D.O. M.D. Other: ______

Physician Printed Name **Physician Credentials (circle one)**

____ _____/_____/______

Physician Signature **Date**

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Clinic Name / Location (print or stamp)