Appendix VI

PHYSICAL EXAMINATION FORMS

- Patient History and Health Questionnaire
- Conduct of the Examination (Internal Medicine)
- Neurological Examination
- Specialty Examination-Dermatology
- Pulmonary Function
- Diagnostic Summary

KS# _____

NAME _____ DATE: _____

PATIENT'S HISTORY AND HEALTH QUESTIONNAIRE

FAMILY HISTORY: HAVE ANY MEMBERS OF YOUR FAMILY EVER HAD THE FOLLOWING? IF SO, PLEASE CHECK BELOW AND NOTE WHICH FAMILY MEMBER.

	Mother	Father	Sister	Brother	Child
Diabetes					
Epilepsy					
Cancer					
High Blood Pressure					
Heart Disease					
Stroke					
Allergy					
Stomach Trouble					
Nervous Trouble					
Blood Disease					
Deformities					
Arthritis					
Other familial diseases:					

Please list: _____

FATHER: Living-Age _____ Condition of Health? _____
Dead-Age _____ Cause of Death? _____

MOTHER: Living-Age _____ Condition of Health? _____
Dead-Age _____ Cause of Death? _____

NUMBER BROTHERS: Living _____ Ages: _____ Dead _____ Causes: _____

NUMBER SISTERS: Living _____ Ages: _____ Dead _____ Causes: _____

ARE YOU MARRIED? _____ NO. OF YEARS _____ WIFE'S AGE: _____ HUSBAND'S AGE _____

Health of Husband or Wife? _____

If spouse dead, give age, year, and cause of death: _____

Previous Marriages? _____ Gives dates: _____

NUMBER OF CHILDREN: Boys: _____ Ages: _____ Girls: _____ Ages: _____

All Healthy? _____ Any dead? _____ Any birth defects? _____
If yes, explain _____

****

PLEASE LIST HERE ANY PHYSICAL OR NERVOUS COMPLAINTS WHICH YOU HAVE: _____

****

PERSONAL HISTORY

Allergy or severe reaction to medicines, foods, plants, chemicals, etc.: Please list:

_____

_____

_____

List Average

Hours worked per day: _____

Hours sleep per night: _____

Days worked per week: _____

Days vacation per year: _____

Number cigarettes per day: _____

Other tobacco per day: _____

Cups coffee per day: _____

Alcoholic drinks per day: _____

Do you take regular exercise? _____

What is your usual weight? _____

What is the most you ever weighed? _____

At what age or year? _____

Have you lost or gained weight? _____

If so, how much? _____

PUT A CIRCLE AROUND ANY OF THE FOLLOWING CONDITIONS WHICH YOU NOW HAVE OR HAVE HAD IN THE PAST:

Skin Trouble
- Acne
- Excess hair growth
- Change of skin color
- Other _____
- _____
- _____

Cataracts
Tonsillitis
Sinusitis
Goiter
Hay fever
Asthma
Bronchitis
Pleurisy
Pneumonia
Tuberculosis
Breast Trouble
Heart Trouble
Stomach Trouble
Gallstones
Ulcer

Jaundice
Liver trouble
Hepatitis
Worms
Dysentery
Colitis
Hemorrhoids
Kidney Trouble
Kidney Stones
Bladder Trouble
Prostate Trouble
Syphyilis
Gonorrhea
Hernia (rupture)
Fainting
Fits or convulsions
Nervous Breakdown
Depression
Paralysis
Muscle Pain
Muscle weakness
Numbness

Loss of sensation
Loss of sex drive
Polio
Mumps
Measles
Rheumatic fever
Malaria
Arthritis
Gout
Anemia
Diabetes
Cancer or Tumor
Varicose Veins
Phlebitis
Rheumatoid Arthritis
Severe Arthritis
Systemic Lupus Erythematosus
Scleroderma

PAST HISTORY: Please list previous operations, injuries, serious illnesses, etc. and year; including those checked off above.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

When was your last physical examination? _____ Any abnormality found? ____

Are you under any medical treatment now? _____ List any medications you take now or occasionally: _____

_____

PERSONAL PHYSICIAN:

Name _____

Street Address _____

City, State & Zip Code _____

IF YOU HAVE HAD REPEATED CASES OF ANY OF THE FOLLOWING IN THE PAST YEAR, PLEASE CIRCLE

Pneumonia

Kidney Infections

Skin Boils

Other Infections (specify)

_____

_____

_____

IF YOU HAVE ANY OF THE FOLLOWING COMPLAINTS, PLEASE CIRCLE YES, IF NOT, CIRCLE NO. THE DOCTOR WILL ASK ABOUT DETAILS LATER. ANSWER ALL QUESTIONS. IF IN DOUBT, GUESS YES OR NO.

Severe headaches or head pains	Yes	No
Do you have:		
Any disturbance in vision	Yes	No
Pain or discomfort in eyes	Yes	No
Wear glasses	Yes	No
Constant noise in ears	Yes	No
Hard of hearing	Yes	No
Ear ache with colds ( ) plane flights ( )	Yes	No
Chronic running ear	Yes	No
Chronic stuffy or runny nose	Yes	No
Need to use nose drops frequently	Yes	No
Bad nose bleeds at times	Yes	No
Frequent severe colds or sore throat	Yes	No
Any known dental problems	Yes	No
Soreness or bleeding of gums	Yes	No
More than a year since teeth checked	Yes	No
Sore mouth or tongue	Yes	No
Goiter or thryoid trouble	Yes	No
Thyroid test -- too high ( ) too low ( )	Yes	No
Feeling of lump in the throat	Yes	No
Need to take thyroid medicine	Yes	No
Hoarseness at times	Yes	No
Recent or chronic cough	Yes	No
Chronic coughing up of sputum	Yes	No
Ever coughed up blood	Yes	No
Ache all over	Yes	No
Having chills or fever	Yes	No
Severe soaking night sweats	Yes	No
Lived with anyone having T.B.	Yes	No
Worried about your heart	Yes	No
Blood pressure -- too high ( ) too low ( )	Yes	No
Pains in heart or chest	Yes	No
Pounding or skipping of heart	Yes	No
Heart starts racing suddenly	Yes	No
Shortness of breath or wheezing	Yes	No

Trouble getting a deep breath	Yes	No
Swelling ankles	Yes	No
Leg cramps in bed or sitting still	Yes	No
Leg cramps while walking	Yes	No
Pain or trouble with swallowing	Yes	No
Poor appetite -- recently ( ) always ( )	Yes	No
Nausea or vomiting	Yes	No
Vomiting of blood	Yes	No
Belching, bloating or indigestion	Yes	No
Yellow skin or eyes (jaundice)	Yes	No
Burning or hunger pains in stomach	Yes	No
Use antacids for stomach burning	Yes	No
Soreness or pain in stomach, abdomen	Yes	No
Suspect ulcers or stomach trouble	Yes	No
Cramps in stomach or low down	Yes	No
Loose bowels or diarrhea	Yes	No
Black or tarry stools (bowel movement)	Yes	No
Fresh or bright blood with stools	Yes	No
Mucus (slime or plegm) in stools	Yes	No
Constipation	Yes	No
Use laxatives ( ) or enemas ( ) frequently	Yes	No
Recent change in bowel habits	Yes	No
Rectal trouble or pain	Yes	No

List any foods which always disagree: _____

_____

Pain in the kidney region	Yes	No
Get up nights to urinate (Number of times _____)	Yes	No
Blood or pus in urine	Yes	No
Albumin in urine	Yes	No
Sugar in urine	Yes	No
Spells of frequent urination	Yes	No
Severe burning or pain on urination	Yes	No
Pains over bladder or low down	Yes	No
Trouble starting urine	Yes	No
Urinary stream has become weak	Yes	No
Hard to empty bladder completely	Yes	No
Lose control of passing urine	Yes	No
Painful or sore genitals (privates)	Yes	No

Swollen or painful joints	Yes	No
Stiffness of muscles or joints	Yes	No
Severe pains in arms or legs	Yes	No
Painful feet	Yes	No
Backache	Yes	No
Pains in neck	Yes	No
Easy to sunburn	Yes	No
Itch or rash (where?)_____	Yes	No
Subject to acne	Yes	No
Subject to boils or infections	Yes	No
Subject ot athlete's foot, skin fungus	Yes	No
Subject to hives or skin reactions	Yes	No
Easy bleeding or bruising	Yes	No
Mole or sore which is not healing	Yes	No
Swelling, lump, or soreness anywhere on body (where?)_____ _____	Yes	No
Severe dizziness	Yes	No
Numbness or tingling (where?) _____	Yes	No
Twitching muscles (where?) _____	Yes	No
Generalized weakness	Yes	No
Muscle weakness	Yes	No
Nail biting	Yes	No
Sleep walking	Yes	No
Bed wetting after age 12	Yes	No
Chronically tired or overworked	Yes	No
Irregular living habits	Yes	No
Can't go to sleep or stay asleep	Yes	No
Nearly always in poor health	Yes	No
From sickly or nervous family	Yes	No
Considered to be a nervous person	Yes	No
Tremble and sweat easily	Yes	No
Have trouble making up your mind	Yes	No
Easily mixed up or confused	Yes	No
Clumsy or have frequent accidents	Yes	No
Feel sad, lonely or depressed	Yes	No
Cry often	Yes	No
Wish you were dead	Yes	No
Worry continually	Yes	No

Upset by little things . . . . . Yes No

A perfectionist . . . . . Yes No

Sensitive or feelings easily hurt . . . . . Yes No

Often misunderstood . . . . . Yes No

Often act on sudden impulse . . . . . Yes No

Easily angered or have violent rages . . . . . Yes No

Frequently keyed up and jittery . . . . . Yes No

Easily scared by sudden noise . . . . . Yes No

Have bad dreams or thoughts . . . . . Yes No

Suspect a serious disease or cancer . . . . . Yes No

Having trouble getting along with someone at home or work . . . . Yes No

Have you ever been exposed to any of the following substances or types of radiation? Exposure is defined as skin or respiratory contact more than one day's duration.

1. Coal tar . . . . . Yes No
2. creosote . . . . . Yes No
3. anthrocene . . . . . Yes No
4. benezene . . . . . Yes No
5. benzidine . . . . . Yes No
6. naphthylamine . . . . . Yes No
7. aminodiphenyl . . . . . Yes No
8. mustard gas . . . . . Yes No
9. vinyl chloride . . . . . Yes No
10. chloromethyl ether . . . . . Yes No
11. arsenic . . . . . Yes No
12. chromates . . . . . Yes No
13. asbestos . . . . . Yes No
14. cutting oils . . . . . Yes No
15. trichloroethylene . . . . . Yes No

16. Ultra-violet light (other than sun) . . . . . Yes No

17. x-rays (other than routine . . . . . Yes No

18. ionizing radiation . . . . . Yes No

COMMENTS: For each "YES" exposure in the preceding list, please fill out the following:

1. Type of Exposure (coal tar, etc). _____

   A. Was exposure received on the job? Yes _____ No _____

   B. If yes, job title _____

   C. If no, how exposure received _____

   _____

   D. Circle frequency of exposure that best fits your experience:

   Daily Weekly Monthly Yearly

   E. In what year(s) were you exposed? _____

2. Type of Exposure (coal tar, etc) _____

   A. Was exposure received on the job? Yes _____ No _____

   B. If yes, job title _____

   C. If no, how exposure received _____

   _____

   D. Circle frequency of exposure that best fits your experience:

   Daily Weekly Monthly Yearly

   E. In what year(s) were you exposed? _____

3. Type of Exposure (coal tar, etc) _____

   A. Was exposure received on the job? Yes _____ No _____

   B. If yes, job title _____

   C. If no, how exposure received _____

   _____

   D. Circle frequency of exposure that best fits your experience:

   Daily Weekly Monthly Yearly

   E. In what year(s) were you exposed? _____

CONDUCT OF THE EXAMINATION

NAME _____ DATE _____

DATE OF BIRTH (DOB) _____ CASE NO. _____

PHYSICAL EXAMINATION

1. General Appearance
   a. Appearance/Stated Age: ( ) Younger Than ( ) Older Than ( ) Same As
   b. Well-nourished ( ) ( ) Obese ( ) Under-nourished
   c. Appearance of illness or distress ( ) Yes ( ) No
   d. Hair distribution: ( ) Normal ( ) Abnormal
   Specify: _____

2. Height (cm) | Weight (Undressed) kg | Sitting Blood Pressure Right Arm at Heart Level
   Temp. Oral F. | Systolic _____ Diastolic _____

3. Pulse rate _____ Regular: ( ) Yes ( ) No
   a. Irregular ( ) b. Irregularly irregular ( ) c. VPBs per minute _____
   Describe any irregularities: _____

4. Eye Grounds: ( ) Normal ( ) Abnormal
   ( ) A-V nicking ( ) Hemorrhages
   ( ) ↑ light reflex ( ) Exudates
   ( ) Arteriolar spasm ( ) Disk Pallor
   ( ) Papilledema ( ) ↑ Cupping
   Describe any vascular lesions, hemorrhages, exudates, or papilledema: _____

5. Arcus Senilis: ( ) Present ( ) Absent 5a. Abnormal Ocular Pigmentation ( ) Yes ( ) No

6. ENT: ( ) Normal ( ) Abnormal
   Right Tympanic Membranes intact ( ) Yes ( ) No
   Left Tympanic Membranes intact ( ) Yes ( ) No
   Nasal Ulcerations ( ) Yes ( ) No
   Describe any abnormality: _____

7. Neck (Especially thyroid gland): ( ) Normal ( ) Abnormal
   Thyroid gland palpable ( )
   Enlarged ( )
   Nodules ( )
   Tenderness ( )
   Parotid gland enlargement Right ( ) Left ( )
   Carotid pulse absent Right ( ) Left ( )
   Carotid bruit Right ( ) Left ( )
   Comment: _____

8. Thorax and Lungs: ( ) Normal ( ) Abnormal

( ) Asymmetrical expansion
( ) Hyperresonance
( ) Dullness
( ) Wheezes
( ) Rales

Describe any abnormality especially basilar rales:

_____
_____
_____

Circumference at nipple level: Expiration _____ cm Inspiration _____ cm

9. Heart: ( ) Normal ( ) Abnormal

Displacement of apical impulse ( ) Yes ( ) No
Heart sounds normal ( ) Yes ( ) No ( ) S_1 ( ) S_2 ( ) S_3 ( ) S_4
Precordial thrust ( ) Yes ( ) No

Heart and Other Observations

Murmur ( ) No ( ) Yes

	Ao	Pu.	Apex	Mitral (lt.lat)
Sys	( )	( )	( )	( )
Dia	( )	( )	( )	( )

Describe any enlargement, irregularity of rate, murmurs, or thrills:

_____
_____
_____
_____

10. Abdomen: ( ) Normal ( ) Abnormal Waist Measurement _____

( ) Heptomegaly
_____ cm. Liver span
( ) Spleenomegaly

Tenderness Liver ( )
Tenderness Spleen ( )
Tenderness Other ( )
Other mass: ( )

Describe any abnormality with special attention to the spleen and liver:

_____
_____
_____

11. Extremities: ( ) Normal ( ) Abnormal

( ) Absence, specify: _____
( ) Edema
Pitting ( ) Non-pitting ( )
( ) Clubbing of nails
( ) Varicosities
( ) Loss of hair on toes right
( ) Loss of hair on toes left

Describe any edema or signs of vascular insufficiency:

_____
_____
_____
_____

12. Peripheral Pulses

	Normal	Dimin.	Absent	Comments:
Radial				
Femoral				
Popliteal				
Dorsalis Pedis				
Posterior Tibial				

13. Musculoskeletal: ( ) Normal ( ) Abnormal

MUSCLE

Weakness ( )
Tenderness ( )
Abnormal Consistency ( )
Atrophy ( )

Comments: _____

SPINE

Scoliosis ( )
Kyphosis ( )
Tenderness ( )
Tenderness level _____
Decreased range of motion ( )
Pelvic tilt ( )
Spine SLR RT ( )
Spine SLR LFT ( )

14. Genitourinary/Rectal/Hernia ( ) Normal ( ) Abnormal

( ) Inguinal hernia Rt.
( ) Inguinal hernia Lft.

( ) Varicocele
( ) Epididymis
( ) Scrotal mass
____ cm dia.

( ) Hemorrhoids
( ) Prostatic enlargement
( ) Rectal mass

	Absent	Enlarged	Atrophic
Testes Rt.	( )	( )	( )
Testes Lft.	( )	( )	( )

Comments: _____

15. Lymph Nodes (Check all areas) ( ) Normal ( ) Abnormal-Specify:

	Enlarged	Tender	Hard	Fixed	Confluent
Cervical	( )	( )	( )	( )	( )
Occipital	( )	( )	( )	( )	( )
Supraclavicular	( )	( )	( )	( )	( )
Axillary	( )	( )	( )	( )	( )
Epitrachlear	( )	( )	( )	( )	( )
Inguinal	( )	( )	( )	( )	( )
Femoral	( )	( )	( )	( )	( )

16. Nervous System - Separate Examination

17. Other Tests Ordered: ( ) Yes ( ) No

Tests ordered (Specify)

_____ _____

_____ _____

_____ _____

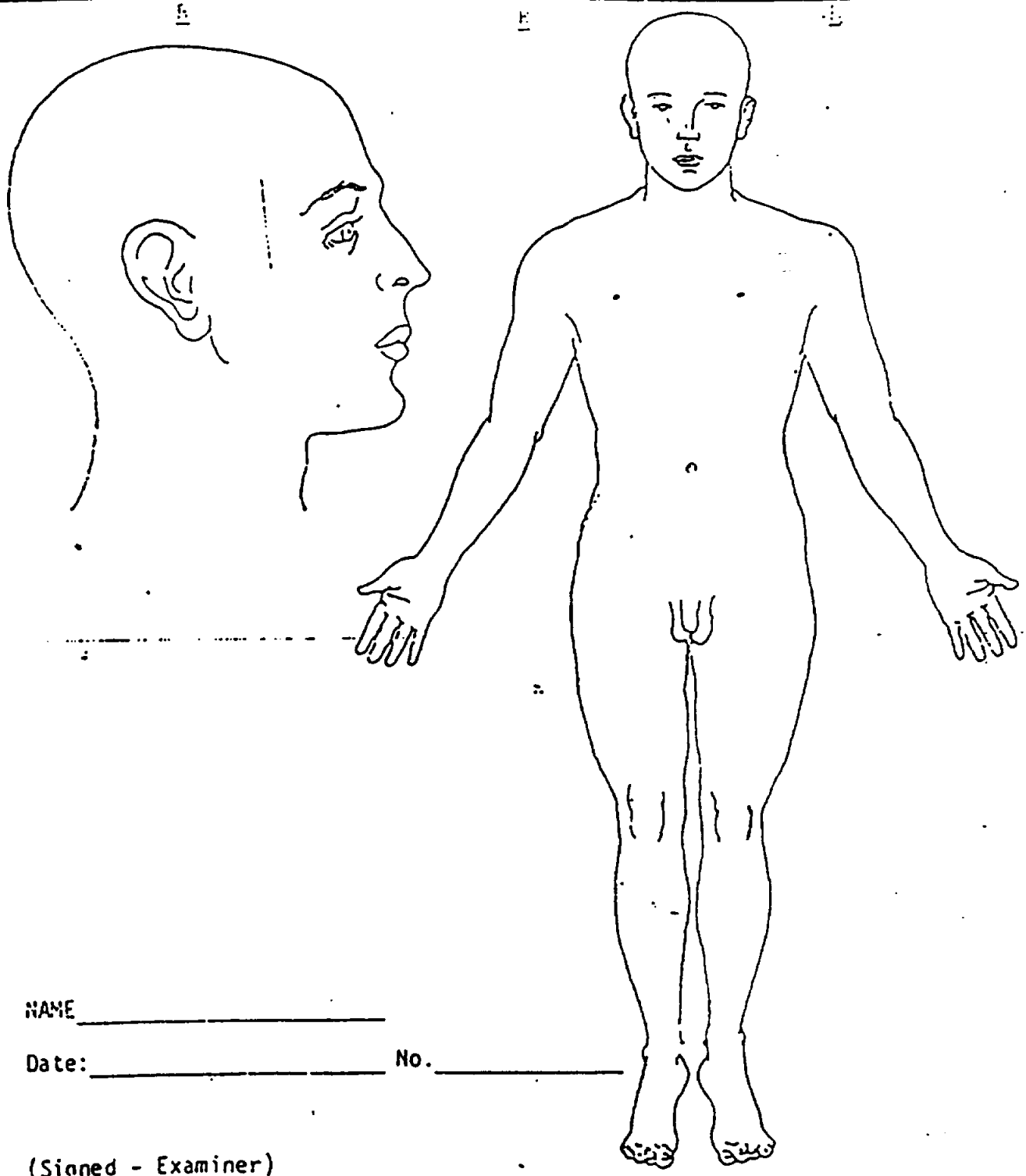
Signed: _____
Examining Physician

Examining Facility:

Printed Name of Examining Physician

Form 531 incl.

CLINICAL RECORD | ANATOMICAL FIGURE



NAME _____

Date: _____ No. _____

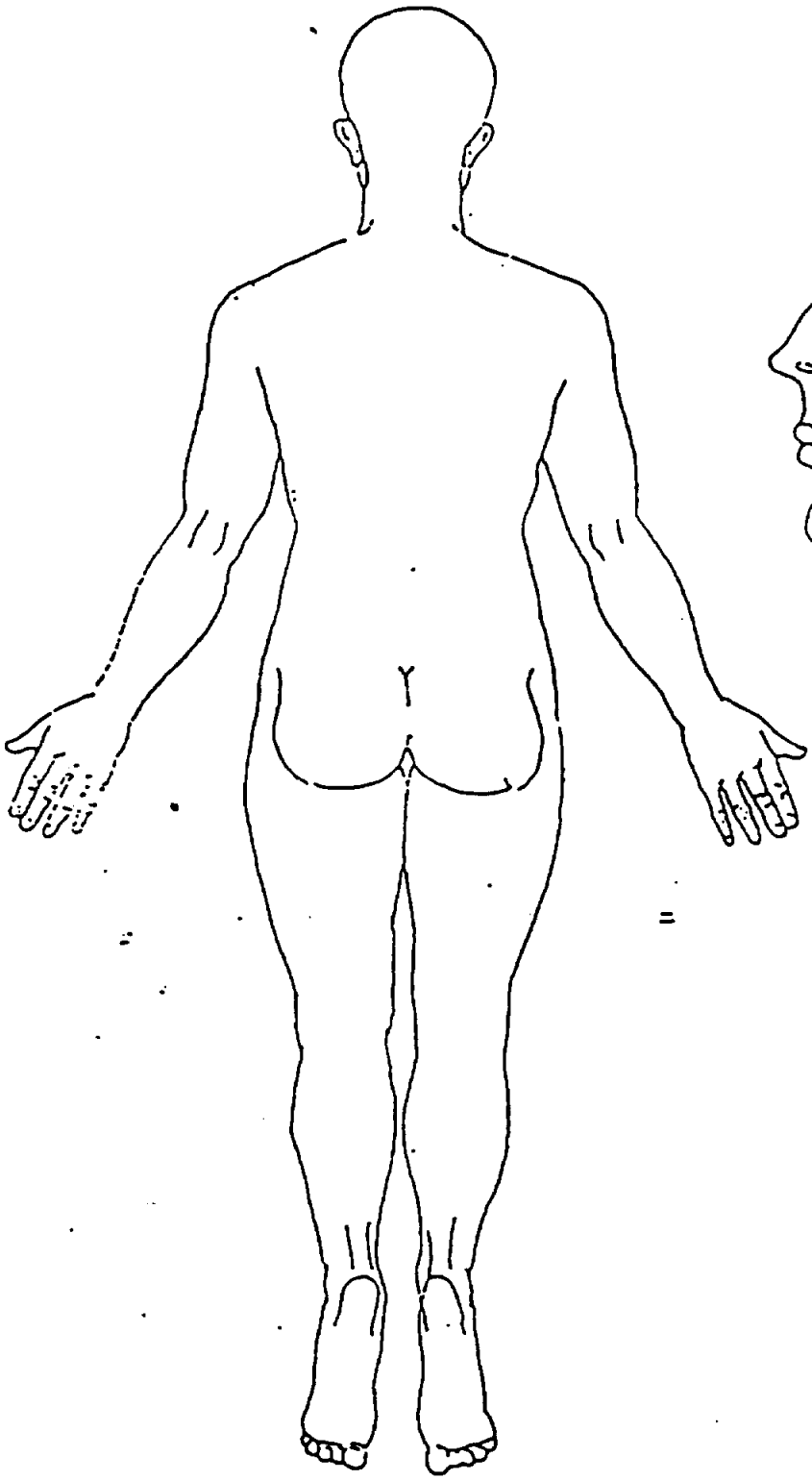
(Signed - Examiner) _____

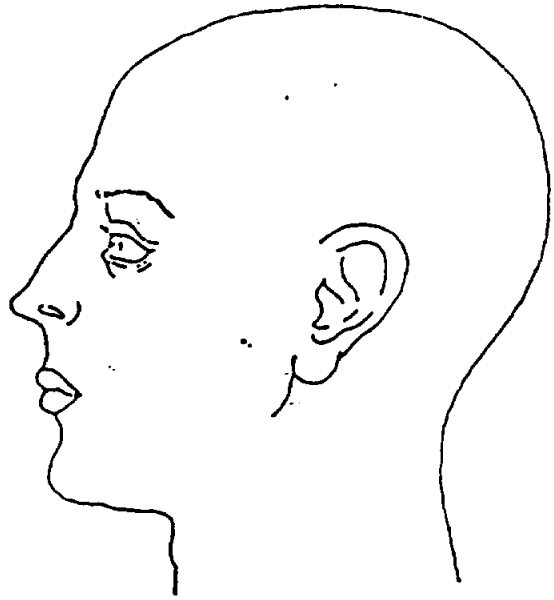
PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle, grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

ANATOMICAL FIGURE
Standard Form 51

Standard Form 5[illegible]





Name: _____ Date: _____ No. _____

(Signed - Examiner) _____

SPECIALTY EXAMINATION - EXAMINER - (1 of 2)

NEUROLOGICAL EXAMINATION

NAME _____ DATE _____

CASE NO. _____

HEAD & NECK

	Yes	No
Normal to Palpations/Inspections	( )	( )
Specify: ( ) Scar ( ) Assemmetry ( ) Depression		
Neck Range of Motion - Normal	( )	( )
Decreased ( ) Left ( ) Right ( ) Forward ( ) Back		

MOTOR SYSTEM

Handedness ( ) Right
( ) Left

Gait - Normal or	( )	( )
( ) Broad Based ( ) Ataxic ( ) Small Stepped ( ) Other Comments _____		

MUSCLE STATUS (Strength, Tone, Volume, Tenderness, Fibrillations)

	Normal	Abnormal	Increased Right	Increased Left	Decreased Right	Decreased Left
Rt. Arm Swing	( )	( )	( )	( )	( )	( )
Left Arm Swing	( )	( )	( )	( )	( )	( )
Muscle Bulk	( )	( )				
Tone - upper ext.	( )		( )	( )	( )	( )
Lower ext.	( )		( )	( )	( )	( )
Strength - Distal Wrist Extensors	( )		( )		( )	
Ankle/Toe Dors/. Flexors	( )				( )	( )
roximal Deltoids	( )				( )	( )
ip Flexors	( )				( )	( )

KS-AF-4 rev.

	Yes	No
ABNORMAL MOVEMENTS (Tremors, Tics, choreas, etc)	( )	( )
Fasiculations If yes (1-4+) _____	( )	( )
Tenderness If yes, (1-4+) _____	( )	( )
Tremor (if yes, specify below)	( )	( )

	Resting	Essential	Intention	Other
Upper Extremities Rt.	( )	( )	( )	( )
Upper Extremities Lt.	( )	( )	( )	( )
Lower Extremities Rt.	( )	( )	( )	( )
Lower Extremities Lt.	( )	( )	( )	( )

COORDINATION	Normal	Abnormal
a. Equilibratory - Eyes Open		
Right Foot	( )	( )
Left Foot	( )	( )
Equilibratory - Eyes Closed		
Right Foot	( )	( )
Left Foot	( )	( )

b. Non-Equilibratory	Normal	Abnormal Rt.	Abnormal Left	Abnormal Both
Finger to Nose	( )	( )	( )	( )
Finger to Finger	( )	( )	( )	( )
Heel to Knee	( )	( )	( )	( )
Finger to Nose to Finger	( )	( )	( )	( )
Heel-Knee-Shin	( )	( )	( )	( )
c. Succession Movements (Including cheek, rebound posture-holding)	( )	( )	( )	( )
Rapidly Alternative Movements	( )	( )	( )	( )

SKILLED ACTS- PRAXIS	Normal	Abnormal
a. Handwriting (if indicated)	( )	( )
b. Speech (articulation, aphasia, agnosia) Grossly	( )	( )

if abnormal specify
( ) Dysarthia
( ) Aphasia

Reflexes (Code 0=absent, 1=sluggish, 2=active, 3=very active, 4=transient clonus, 5=sustained clonus, 6=other SPECIFY UNDER COMMENTS BELOW)

	Right	Left
Biceps	( )	( )
Triceps	( )	( )
Patellar	( )	( )
Achilles	( )	( )
Cremasteric	( )	( )
Abdominal	( )	( )
Abnormal Babinski Present? No ( ) Yes ( )	( )	( )

COMMENTS _____

_____

_____

MENINGEAL IRRITATION

	Normal	Abnormal		
		Rt.	Left	Both
Straight leg raising	( )	( )	( )	( )

SENSORY SYSTEM (tactile, pain vibration, position . If positive sensory signs are present summarize below and indicate details on Anatomical - Standard Form 531)

	Normal	Abnormal		
		Rt.	Left	Both
Light Touch	( )		( )	
Pin Prick	( )		( )	
Vibration (@ ankle, 128hz Tuning Fork)	( )	( )	( )	( )
Position (Great Toe)	( )	( )	( )	( )

CRANIAL NERVES	Present	Absent
Right-smell	( )	( )
Left - smell	( )	( )

	Normal	Abnormal
FUNDUS - Right:	( )	( )
If abnormal:		
( ) Disk Pollar Atrophy		
( ) Exudate		
( ) Papilledema		
( ) Hemorrhage		
Fundus - Left:	( )	( )
If abnormal:		
( ) Disk Pollar Atrophy		
( ) Exudate		
( ) Papilledema		
( ) Hemorrhage		
FIELDS - Right to confrontation	( )	( )
Fields - Left	( )	( )

PUPILS

Size _____ mm	( ) equal	( ) unequal	difference _____
Shape, position	( ) round	( ) other rt.	( ) other left
Light, reaction	( ) normal	( ) abnormal rt.	( ) abnormal left

Position of Eyeballs
( ) normal
( ) deviation medial rt. ( ) deviation lateral rt.
( ) deviation medial lt. ( ) deviation lateral lt.
( ) deviation medial both ( ) deviation lateral both

Movements ( ) ( )
if abnormal describe _____

_____

NYSTAGMUS ( ) rotary ( ) horizontal ( ) vertical ( ) None

Draw position:

PTOSIS ( ) None ( ) right ( ) left

MOTOR

	Symmetric	Deviated Right	Deviated Left
Clench Jaw, rt.	( )	( )	( )
Clench Jaw, left	( )	( )	( )

SENSORY

	Normal	Abnormal V_1	Abnormal V_2	Abnormal V_3
Sensory right	( )	( )	( )	( )
Sensory left	( )	( )	( )	( )

CORNEAL REFLEX

( ) present right ( ) Absent Right
( ) present left ( ) Absent left

MOTOR RIGHT

	Yes	No
Normal Smile Rt.	( )	( )
Normal Smile Left	( )	( )

Palpebral Fissure ( ) Normal ( ) Abnormal

PALATE AND UVULA	Normal	Deviation
Movement	( )	Rt. ( ) Left ( )
Palatal Reflex Rt.	( ) normal	( ) abnormal
Palatal Reflex Left	( ) normal	( ) abnormal
Tongue-Protruded	( ) Central	( )Right ( ) Left
Atrophy	( ) No	( ) Yes

MENTAL STATUS (Alert, clear, cooperative, etc)

Gross abnormalities ( ) yes ( ) no

If yes, specify: _____

_____

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

_____

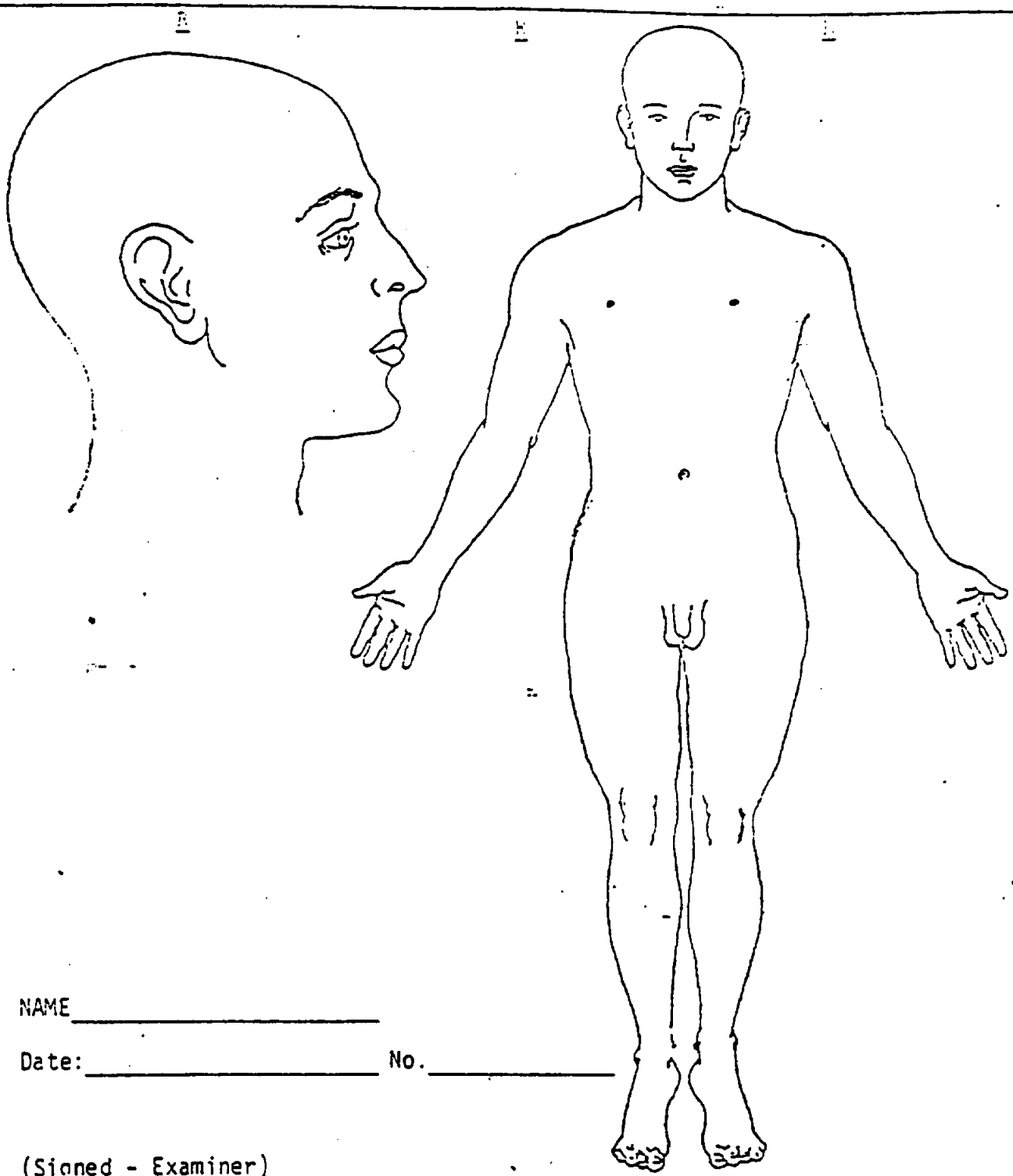
_____

_____

_____

Signed _____
Examining Physician

CLINICAL RECORD	ANATOMICAL FIGURE



NAME _____

Date: _____ No. _____

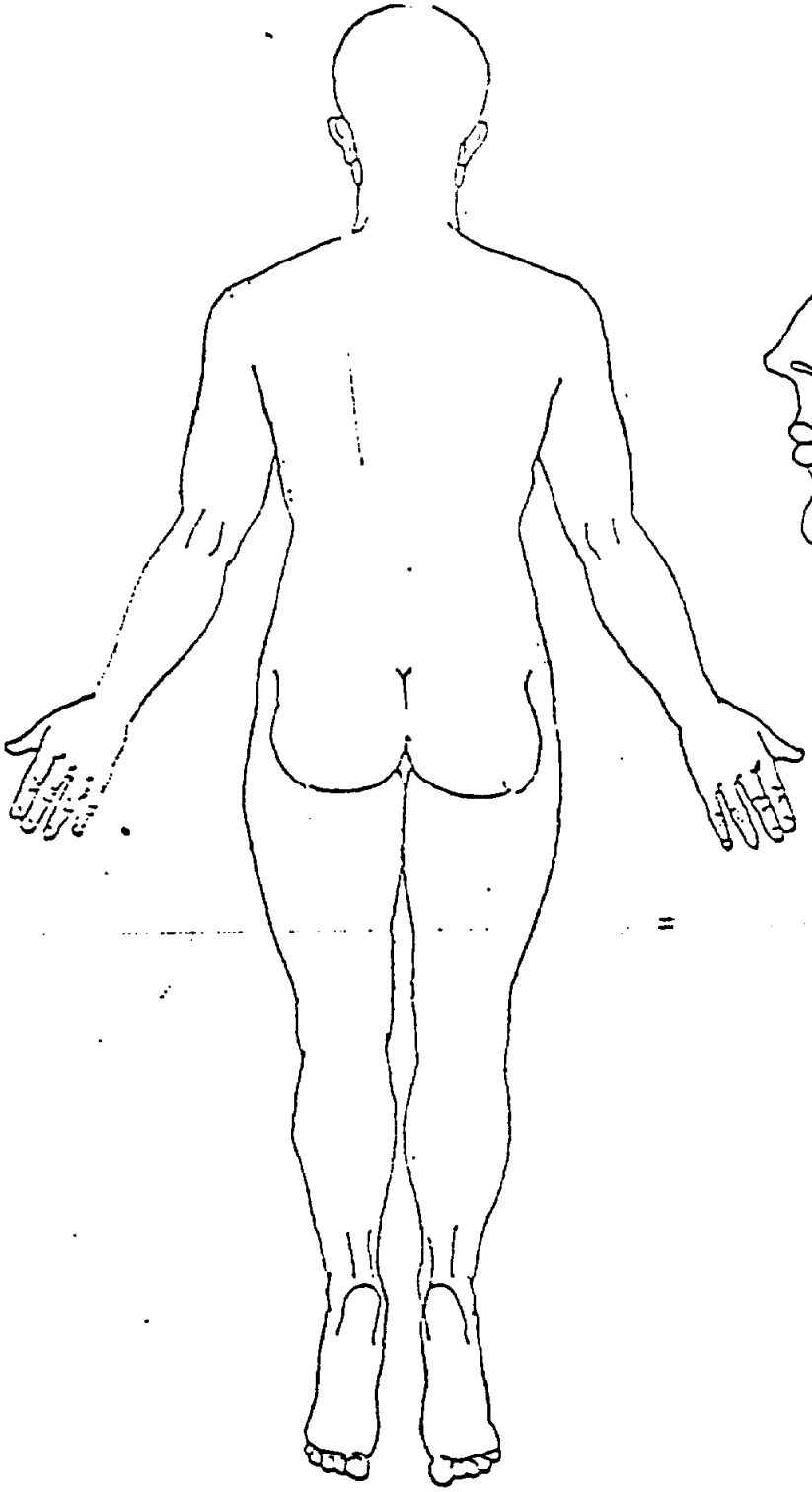
(Signed - Examiner) _____

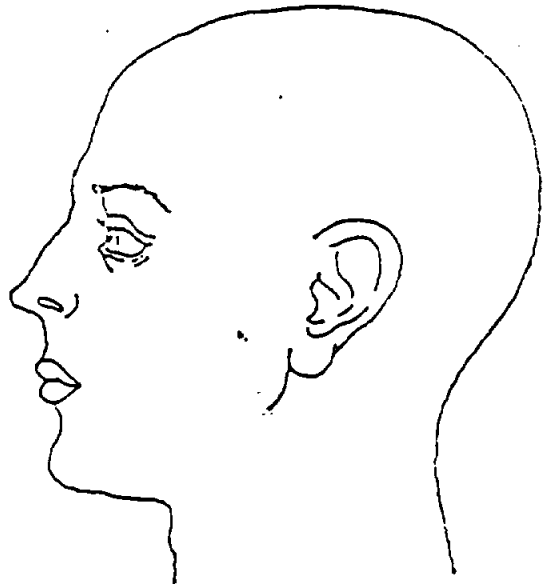
PATIENT'S IDENTIFICATION (For typed or written entries like: Name—last, first, middle, grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.

ANATOMICAL FIGURE
Standard Form 531
AM-124

KS-AF-4

Standard Form 531





Name: _____ Date: _____ No. _____

(Signed - Examiner)

SPECIALTY EXAMINATION - NEUROLOGY - (1 of 2)

Standard Form 531

:IALTY EXAMINATION - DERMATOLOG

NAME_____ _____

Date_____

No._____

Skin:

Normal ( ) Abnormal ( ) - Indicate type and location of lesions on the anatomical figure - attached

( ) Comedones

( ) Acneiform lesions

( ) Acneiform Scars

( ) Depigmentation

( ) Inclusion Cysts

( ) Cutis Rhomboidalis

( ) Hyperpigmentation

( ) Jaundice

( ) Spider Angiomata

( ) Palmer Erythema

( ) Palmer Keratosis

( ) Petechiae

( ) Ecchymoses

( ) Conjunctiva

( ) Oral Mucosa

( ) Finger Nails

( ) Toe Nails

( ) Soles of Feet

( ) Dermatographia

******

Photographs taken? If so indicate areas photographed: (ONLY SUSPECT LESIONS)

( ) Face (right) ( ) Neck ( ) Chest

( ) Face (left) ( ) Shoulders ( ) Stomach

( ) Face (Full)

BIOPSY

( ) Skin Biopsy Performed (Check if yes) Consent Form obtained? Yes ( ) No ( )

_____Biopsy location

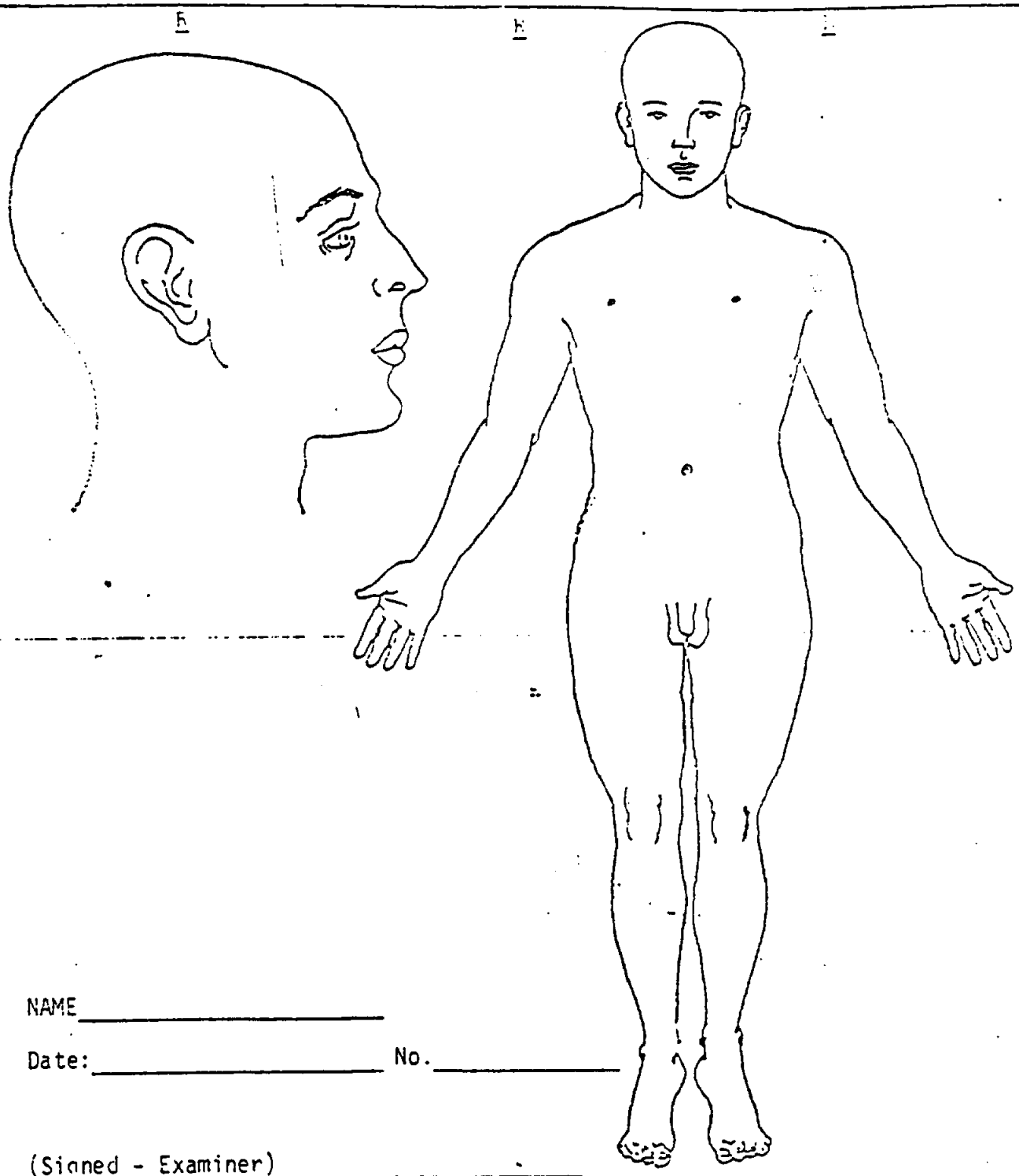
COMMENTS:_____

_____

_____

Signed_____

CLINICAL RECORD	ANATOMICAL FIGURE



NAME _____

Date: _____ No. _____

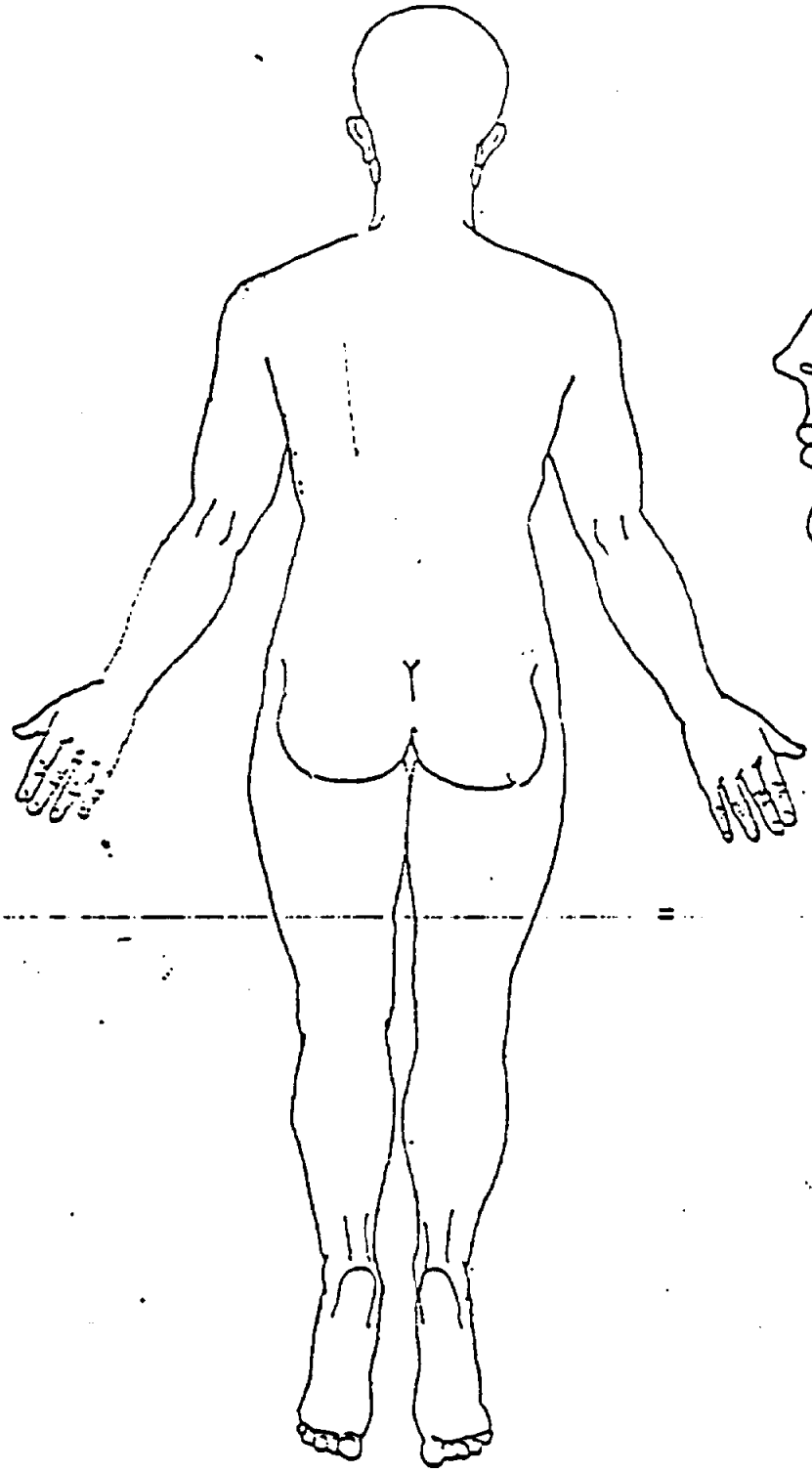
(Signed - Examiner) _____

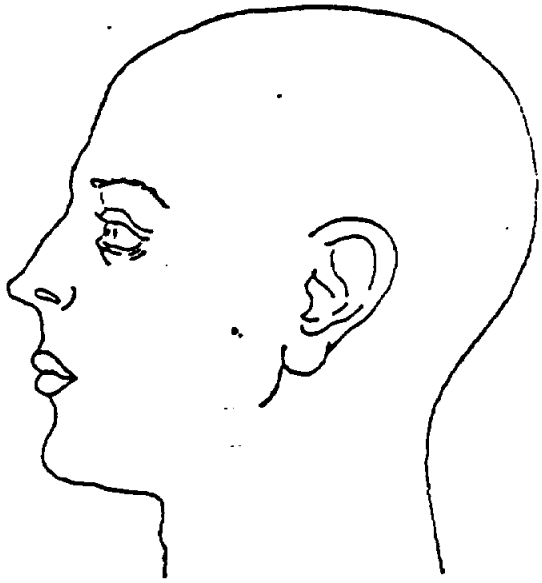
PATIENT'S IDENTIFICATION (For typed or written entries use: Name-last, first, middle, grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.

ANATOMICAL FIGURE
Standard Form 531
AVI-24

Standard Form 531

KS-AF-2





Name: _____ Date: _____ No. _____

(Signed - Examiner)

SPECIALTY EXAMINATION - DERMATOLOGY - ANATOMICAL FIGURE (1 of 2)

Standard Form 531

KS-AF-2

PULMONARY FUNCTION

NAME_____ Test Date_____

Age_____

Case No._____

	Actual	Predicted	%
FVC	_____	_____	_____
FEV-1	_____	_____	_____
FEV-1/FVC	_____ %	_____	_____

*Comments regarding test performance:_____

_____

_____

Testing Technician_____

*complete only if performance is questioned - i.e., cold, bronchitis, etc.

Equipment Used: Breon Spirometer

COMMENTS OF REVIEWING PHYSICIAN _____

_____

_____

Signature_____
Reviewing Physician

KS-AF-3 rev.

DATE:

NAME: NUMBER: AGE: TEMPERATUR

NERVE	SITE	RECORD	GAIN	DISTANCE	STM. CURR.	C.V.	LAT.	D
ULNAR	WRIST		5K	CM				
	BELOW ELBOW		5K	CM				
	ABOVE ELBOW		5K	CM				
PERONEAL	ANKLE		2K	CM				
	FIBULAR HEAD		2K	CM				
SURAL			10	14 CM				

COMMENTS:

NAME: _____ _____

DIAGNOSTIC SUMMARY

SYNOPSIS OF POSITIVE FINDINGS

Medical History:

1. _____
2. _____
3. _____
4. _____
5. _____

PHYSICAL EXAMINATION (Complete below and continue on additional page - reference no.)

1. General

_____
_____
_____
_____

2. Dermatologic

_____
_____
_____
_____
_____

3. Neurological Including Nerve Conduction Studies

_____
_____
_____
_____
_____

4. Psychological (Bianary Provided)

_____
_____
_____

DIAGNOSTIC SUMMARY

SYNOPSIS OF POSITIVE FINDINGS

Medical History:

1. _____
2. _____
3. _____
4. _____
5. _____

PHYSICAL EXAMINATION (Complete below and continue on additional page - reference no.)

1. General

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2. Dermatologic

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3. Neurological Including Nerve Conduction Studies

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4. Psychological (Bianary Provided)

_____
_____
_____
_____