Silver Psychiatric Services, PC
Randie Schacter, DO
212 W. Matthews Street, Suite 106
Matthews, NC 28105
Tel 704-847-0424 Fax 704-847-0454
www.silverpsychiatric.com

Report of Physical Examination

Dear Physician:
Thank you for your assistance in filling out this physical exam form. It will provide pertinent information that will be useful in the evaluation and treatment of this person.

_____ _____ _____
Patient's Name Age Telephone Number
Date of last complete physical exam: _____
Brief statement of any pertinent findings in patient's medical history. (If available, please include any history of perinatal problems, developmental delay, trauma, or neurological difficulties):
_____
_____
_____
_____
_____
_____
Known Allergies: _____
Current medications (dosage and purpose): _____
_____
_____
_____
History of Hospitalizations: _____
_____
_____
_____
Report of x-rays, special procedures or significant lab data: _____
_____
_____
_____

Please also enclose a copy of their growth chart.

Physical Examination

Date of physical exam: _____
Height _____ weight _____ Blood Pressure _____ Pulse _____
Respiratory Rate: _____

(Check if normal, explain any abnormalities)

____ Skin _____
___ Lymph Nodes _____
___ Head _____
___ Ears _____
___ Eyes _____ Fundi _____
___ Nose _____
___ Mouth _____
___ Throat _____
___ Neck _____
___ Chest _____
___ Heart _____
___ Back _____
___ Abdomen _____
Is liver enlarged? ___Yes ___No
Is spleen palpable? ___Yes ___No
___ Genitalia _____
___ Rectal _____
___ Extremities _____
___ Neurologic Exam Cranial Nerves II-XII _____
Cerebellar Function _____ Sensory _____
Coordination _____

Impression (please state if normal physical exam or note any abnormalities):

_____
_____
_____
_____
_____
_____
_____

_____
Date Name of Physician Signature

_____
Address Phone number

Patient name: _____ DOB: _____