# Physical Exam

**STUDY NAME**

**Protocol Number:**

**Pt\_ID:**

**Visit Date:**

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**Visit Type:** Checkbox. **Screening** Checkbox. **Baseline** Checkbox. **Visit 1**

Checkbox. **Visit 2** Checkbox. **Visit 3** Checkbox. **Visit 4**

Checkbox. **Visit 5** Checkbox. **Completion Visit**

| **Category** | **Normal or Abnormal** | **If abnormal, describe below** | **Change from baseline** |
| --- | --- | --- | --- |
| **General Appearance** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **HEENT (Head, Eye, Ear, Nose, Throat)** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Neck** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Chest and Lungs** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Cardiovascular** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Abdomen** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Genitourinary** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Rectal** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Musculoskeletal** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Lymph Nodes** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Extremities/ Skin** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Neurological** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |
| **Other, specify:  \_\_\_\_\_\_\_\_\_\_\_** | Checkbox. Normal  Checkbox. Abnormal  Checkbox. Not Examined |  | Checkbox. Yes  Checkbox. No  Checkbox. NA |

**Note:** *For followup PE, if a body system category changes from “Normal” at baseline to “Abnormal” at followup due to a new disease/condition or if a preexisting disease/condition worsens from the baseline, an adverse event form should be completed to report the change.*

Physician Signature:

Date signed: / / .

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