

Physical Examination

Date of examination:

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
DD			MMM				YYYY			

Were there any abnormalities?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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Record details of any abnormalities on the Medical History record.