FORM D: SCREENING PHYSICAL EXAM FORM

PATIENT ID#: ____ ____ ____

PATIENT INITIALS: ____ ____ ____

Center: _____

Form completed by: _____

Date assessment completed: ___ ___/ ___ ___/ ___ ___ ___ ___

Physical Exam	**A. Results of Exam:** **1= Normal** **2= Abnormal*** **9= Not Evaluated**	**B.** *Is abnormality of clinical relevance for purpose of this study? **1=Yes, EXCLUDES** **2=Yes, does NOT exclude** **3=No**	**C.** *Please provide details on each abnormality below.
1. Oral (mouth)			
2. HEENT (incl. thyroid / neck)			
3. Heart			
4. Lungs			
5. Abdomen (incl. liver, spleen)			
6. Extremities			
7. Skin			
8. Neurological			
9. Lymph Nodes			
10. Musculoskeletal			
11. Pallor			
12. Other (specify)			
13. Other (specify)			
14. Other (specify)			
15. Other (specify)			

18. Exam completed by: _____