RESIDENT OFFSITE PHYSICAL EXAM

Name___________________________________

Date of Birth ____________________

Employee ID #____________________

Phone Number___________________

Position applied for:____________________________Start Date: ____________________

Section A: Vital Signs

Height		Weight		Blood Pressure		Pulse		Respirations	

Section B: Physical Exam

Review of Systems	Normal Yes	Normal No	Comments
General Appearance	☐	☐	______________
Head	☐	☐	______________
Face	☐	☐	______________
Eyes:	☐	☐	______________
EOM's	☐	☐	______________
Pupils (size, reactivity)	☐	☐	______________
Ears	☐	☐	______________
Nose:	☐	☐	______________
Mucous membranes	☐	☐	______________
Deformity	☐	☐	______________
Oropharynx	☐	☐	______________
Neck:	☐	☐	______________
Thyroid	☐	☐	______________
Nodes	☐	☐	______________
Motion	☐	☐	______________
Lungs:	☐	☐	______________
Expansion	☐	☐	______________
Auscultation	☐	☐	______________
Percussion	☐	☐	______________
Heart:	☐	☐	______________
Percussion	☐	☐	______________
PMI	☐	☐	______________
Rhythm	☐	☐	______________
Auscultation	☐	☐	______________

MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA

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Review of Systems	Normal Yes	Normal No	Comments
Lymphatics:	☐	☐	________
Abdomen:	☐	☐	________
Percussion	☐	☐	________
Palpation	☐	☐	________
Auscultation	☐	☐	________
Spine:	☐	☐	________
Flexion	☐	☐	________
Extension	☐	☐	________
Rotation	☐	☐	________
Palpation	☐	☐	________
Shoulders:	☐	☐	________
Overhead Extension	☐	☐	________
Abduction	☐	☐	________
Deformity	☐	☐	________
Elbows/Wrists:	☐	☐	________
Motion	☐	☐	________
Palpation	☐	☐	________
Deformity	☐	☐	________
Hands/Fingers:	☐	☐	________
Grasp	☐	☐	________
Deformity	☐	☐	________
Lower Extremities:	☐	☐	________
Motion	☐	☐	________
Flexion	☐	☐	________
Extension	☐	☐	________
Deformity	☐	☐	________
Neurological:	☐	☐	________
DTS's	☐	☐	________
Romberg	☐	☐	________
Focal Weakness	☐	☐	________
Focal Sensory Defect	☐	☐	________

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Phone Number__________________

Section C: Vision Screening

Corrected: ☐ **Uncorrected:** ☐

	Right Eye	Left Eye	Both Eyes
Near			
Far			

Section D: Color Blindness Testing

If needed, the below resource can be used for testing:
http://retina-amd.org/wp-content/uploads/2017/10/ISHIHARA-TEST.pdf

Method: Isihara ☐ Hardy-Rand-Rittler (HRR) ☐

Plates missed:_________out of __________

Color Blindness: Normal ☐ Abnormal ☐

Section E: OSHA Fit Testing Medical Clearance (https://www.osha.gov/Publications/OSHA3789info.pdf)

A medical evaluation and clearance was performed on the above mentioned employee and based on the information provided by the employee it indicates that he/she is:

Cleared without restrictions ☐
Cleared w/restrictions ☐ ____
Not cleared for respirator usage ☐

Section F: Accommodations

Does this candidate need any reasonable accommodations in order to perform their role safely? Yes ☐ No ☐

Please comment on all abnormal findings and/or accommodations needed:

I certify that I have examined the above named individual and the findings indicated are all found to be true and represented accurately.

Medical Evaluator's Printed Name	
Medical Evaluator's Signature	
Date	