

**PRN Targeted Physical Exam**

<b>01</b>	Date of Exam:	___ / ___ / _____ (dd/mm/yyyy)
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**Physical Exam**

		Not evaluated	Normal	Abnormal	If applicable, specify abnormality <small>! Document abnormal findings on Pre-existing conditions Log.</small>
<b>02</b>	General appearance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>03</b>	Heart/Cardiac:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>04</b>	Lung/Respiratory:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>05</b>	Abdomen:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>06</b>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**Vital Signs**

<b>07</b>	Blood pressure - Systolic:	
	<small>! Mark "ND" if blood pressure was Not Done</small>	_____
<b>08</b>	Blood pressure - Diastolic:	
	<small>! Mark "ND" if blood pressure was Not Done</small>	_____

<b>09</b>	Notes/Comments:

CRF Completed By: \_\_\_\_\_ (initials)

CRF Completion Date: \_\_\_ / \_\_\_ / \_\_\_\_\_ (dd/mm/yyyy)