

## STOP II

### PHYSICAL EXAMINATION

\*\*\*AFFIX PATIENT'S LABEL HERE\*\*\*

A1. Person performing physical examination (Name): \_\_\_\_\_ (Initials):

A2. Date of Physical Exam (Month/Day/Year): \_\_\_\_/\_\_\_\_/\_\_\_\_

#### B. MEASUREMENTS

B1. Height (cm):  .

B2. Weight (kg):  .

B3. Blood Pressure (Supine, before blood drawing): a.  b.   
Systolic Diastolic

B4. Pulse (beats/min):

B5. Respiration rate/min:

B6. Temperature (°C):  .

#### C. PHYSICAL EXAMINATION

C1. General Appearance  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

C2. Eyes  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

C3. Ears  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

C4. Nose/Throat/Mouth  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

b. Tonsils  1. NORMAL  2. ENLARGED  3. ABSENT

C5. Lungs

	1. ABSENT	2. PRESENT
a. Rales	<input type="checkbox"/>	<input type="checkbox"/>
b. Rhonchi	<input type="checkbox"/>	<input type="checkbox"/>
c. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
d. Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>
e. Other lung/respiratory abnormality	<input type="checkbox"/>	<input type="checkbox"/> → e1. Specify _____

C6. Heart

	1. ABSENT	2. PRESENT
a. Rhythm abnormality	<input type="checkbox"/>	<input type="checkbox"/> → a1. Specify type: _____
b. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/> → b1. Specify type: _____
c. Other abnormality	<input type="checkbox"/>	<input type="checkbox"/> → c1. Specify type: _____

C7. Abdomen  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

C8. Spleen  1. NOT ENLARGED  2. ENLARGED  3. N/A: S/P splenectomy

↓

C8.a Distance below LCM at MCL (cm)   .

C9. Liver  1. NOT ENLARGED  2. ENLARGED

a. Tenderness  1. ABSENT  2. PRESENT

C10. Extremities

a. Pain or limitation of motion in	1. NO	2. YES
1. Right hip?	<input type="checkbox"/>	<input type="checkbox"/>
2. Left hip?	<input type="checkbox"/>	<input type="checkbox"/>
3. Right shoulder?	<input type="checkbox"/>	<input type="checkbox"/>
4. Left shoulder?	<input type="checkbox"/>	<input type="checkbox"/>

b. Leg ulcer  1. ABSENT  2. PRESENT → b1.  1. RIGHT  2. LEFT  3. BOTH

c. Lower extremity edema  1. ABSENT  2. PRESENT → c1.  1. RIGHT  2. LEFT  3. BOTH

C11. Skin  1. NORMAL  2. ABNORMAL → a. Describe \_\_\_\_\_

C12. Lymph nodes enlarged?  1. NO  2. YES → a. Specify \_\_\_\_\_

Signature of Study Coordinator: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_