OPTIMAL HEALTH
MANAGEMENT LLC

HORMONIZE HEALTH

MEDICAL EVALUATION		
To be completed and singed by a Health Care Provider ONLY.		
Patient Name:	**DOB:**	**Has had a complete history and physical exam on the following date:** _____

VITAL SIGNS						
Height (Feet): _____	**Height (Inches):** _____	**Weight (lbs):** _____	**BP:** ___/___	**BMI:** _____	**HR:** _____	**Temp (F):** _____

PHYSICAL EXAM			
	Normal	Abnormal	
Appearance		○	
Integument	○	○	
HEENT	○	○	
Chest/Lungs/ Heart	○	○	
Abdomen	○	○	
GU/Renal/Genetalia	○	○	
MS/Extremities/Spine	○	○	
Neuro / Psych	○	○	

ASSESSMENT & RECOMMENDATION(S)	
Signature of Health Care Provider	
Name and title of Health Care Provider (Please print or stamp): _____	Date Signed: _____
Office Address, Phone, and Fax (Please print or stamp):	