

Investigational Title: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

Participant ID: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please check the appropriate box and, if abnormal, describe.*

	Normal	Abnormal (Describe if abnormal)
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:**

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Initials of authorized research team: \_\_\_\_\_ Date: \_\_\_\_\_

Investigator Signature: \_\_\_\_\_ Date: \_\_\_\_\_