

PHYSICAL EXAM FORM

NAME: _____ DATE OF VISIT _____
 ADDRESS: _____ CITY: _____ ZIP: _____
 PHONE: _____ DOB: _____ RACE: _____ SEX: _____
 FAMILY PHYSICIAN: _____ ADDRESS: _____ LAST VISIT: _____
 FAMILY DENTIST: _____ ADDRESS: _____ LAST VISIT: _____
 ALLERGIES: _____

IMMUNIZATION STATUS AT VISIT

() COMPLETE

() INCOMPLETE

DTP	1	_____	OPV	1	_____
DTP	2	_____	OPV	2	_____
DTP	3	_____	OPV	3	_____
DtaP	4	_____	OPV	4	_____
DtaP	5	_____	HIB	1	_____
DTP/HIB	1	_____	HIB	2	_____
DTP/HIB	2	_____	HIB	3	_____
DTP/HIB	3	_____	HIB	4	_____
DTP/HIB	4	_____	MMR	1	_____
TD	1	_____	MMR	2	_____
TD	2	_____	HBV	1	_____
			HBV	2	_____
			HBV	3	_____
			HBV	4	_____

TUBERCULIN TEST: _____
 MANTOUX APPLIED: _____
 IMMUNIZATION GIVEN: _____

DEVELOPMENTAL TESTING: _____

VISION TESTING: _____

HEARING TESTING: _____

SPEECH TEST: _____

VITAL DATA: T _____ P _____ R _____ BP _____
 HT _____ INCHES OR CMS. _____ % WT _____ LBS. OR KG. _____ %

STATURE: _____

HEAD CIRCUMFERENCE: _____ % _____ up to 3 years old

CHEST CIRCUMFERENCE: _____ % _____ up to 1 year old

LABORATORY

HEMATOCRIT _____ % or HEMOGLOBIN _____ Mg/100ml

URINALYSIS pH _____ BLOOD _____ PROTEIN _____ KEYTONES _____ GLUCOSE _____

UROBILINOGEN _____ NITRITE _____ SPECIFIC GRAVITY _____ IF CLEAR OF CONCENTRATED _____

SICKLE CELL DATE: _____ RESULTS: _____
 BLOOD LEAD DATE: _____ RESULTS: _____

HEALTH EDUCATION: _____

WELL CHILD - PEDIATRIC PHYSICAL EVALUATION

DATE: _____
 NAME: _____ TANNER RATING: _____
 GENERAL: _____

	NORMAL	ABNORMAL	COMMENTS
WELL NOURISHED	_____	_____	_____
WELL DEVELOPED	_____	_____	_____
SKIN & NAILS	_____	_____	_____
HEAD & HAIR	_____	_____	_____
EYES	_____	_____	_____
EARS	_____	_____	_____
NOSE	_____	_____	_____
MOUTH & THROAT	_____	_____	_____
TEETH & GUMS	_____	_____	_____
NECK	_____	_____	_____
CHEST & LUNGS	_____	_____	_____
HEART	_____	_____	_____
ABDOMEN & FEMORALS	_____	_____	_____
GENITALIA	_____	_____	_____
EXTREMITIES	_____	_____	_____
GAIT	_____	_____	_____
NEUROLOGICAL	_____	_____	_____

ASSESSMENT _____

PLAN FOR THIS VISIT _____

EDUCATION PLAN _____

PRIMARY DIAGNOSIS _____

ADDITIONAL _____

REFERRALS _____

THIS IS TO CERTIFY THAT THIS CHILD IS FREE FROM COMMUNICABLE DISEASE AS OF THIS EXAMINATION.

DOCTOR'S SIGNATURE: _____ DATE: _____