PHYSICAL EXAM FORM

Information to be filled out by physician/health care provider:

Name:_____

Age: years_____ months_____

Hemoglobin/Hematocrit:	Lead:	Height: Inches	Weight: Lbs.	Blood Pressure:
Urinalysis Results (if indicated):	Vision: L R	Developmental Screening:		Hearing:

Does the examination reveal any abnormality?	Normal	Abnormal	Not examined	Describe fully any abnormal findings
General Appearance, Posture, Gait				
Speech / Language Development				
Behavior during examination				
Skin				
Eyes: Extraocular Movements				
Ears: Canal, Tympanic Membrane				
Nose, Mouth, Pharynx, Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (include hernias)				
Genitalia				
Extremities, Feet				
Neurological				
Other:				

Disability (diagnosed)	Treatment

Summary of findings and recommendations:_____

_____

_____

_____ _____

Signature of Physician or Health Care Provider Date

Health Agency Where Examination Completed_____

HEALTH INFORMATION
for Preschool/Daycare/Schoolage Children

Information to be filled out by parent/guardian/caregiver prior to physical exam:

Child's Information

Child's Full Name:_____ Date of Birth:_____
Address:_____ Phone:_____
City/State/Zip:_____

Center or Program name where child is enrolled:_____
Date:_____ Address:_____

Physician Information

Name of family physician:_____ Phone:_____
Address:_____
Date of last visit:_____ Reason:_____

General Health Information

Is the child on any medication?_____ If yes, please list and state purpose_____
_____
Has the child been hospitalized?_____ If yes, please explain with dates:_____
_____
Has the child had any surgeries?_____ If yes, please list with dates:_____
_____
Has the child had a dental exam?_____ If yes, date of last visit:_____ Dentist's name:_____
Address:_____ Phone:_____

Illness and Disease Record

Allergy (specify):_____
Asthma:_____
Chicken Pox (date):_____
Convulsive Disorder:_____
Repeated Ear Infections:_____ Tubes:_____
Pneumonia:_____
Frequent Sore Throat:_____
Pregnancy/Delivery Complications:_____
Prematurity:_____ How early?_____
Developmental or Learning Delay:_____
_____
Others:_____
_____

TURN SHEET OVER FOR PHYSICAL EXAM FORM TO BE FILLED OUT BY PHYSICIAN/ HEALTH CARE PROVIDER.

This form was developed by Multi-Agency Partnership Group