

## Physical Examination

Name	Date of Birth	Examining Physician	Date of Examination
Address of Physician			Telephone No.

Is the patient allergic to any drugs or foods?..... No  Yes, specify: \_\_\_\_\_  
 Is the patient currently taking any medication?..... No  Yes, specify: \_\_\_\_\_

Temperature	Pulse	Respiration	Blood Pressure	Weight	Height
Head Circumference (less than 3 years):		Neurological: <input type="checkbox"/> Not done <input type="checkbox"/> Done, results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			

Item	Normal	Ab-normal	Not Done	Describe Abnormality
Vision Screening				Rt. _____ Left: _____
Hearing Screening				Rt. _____ Left: _____
Developmental Level				
Nutritional Status				
Musculoskeletal				
Extremities				
Skin (rash, old or recent scars)				
Head/ Scalp/ Hair				
Eyes, Ears, Nose, Throat				
Mouth and Teeth				
Neck				
Chest				
Lungs				
Heart				
Abdomen				
Hernia				
Genitalia				
Rectum				
Gait				
Coordination				
Developmental Progress				
Speech/Language Development				

**Any immunizations or boosters given today?**..... No  Yes  
 If Yes, specify: Vaccine \_\_\_\_\_,  Dose  Booster-number:  1  2  3  
 Vaccine \_\_\_\_\_,  Dose  Booster-number:  1  2  3

**Any tests run today?**..... No  Yes  
 If Yes, specify: Test Name \_\_\_\_\_, results  Normal  Abnormal  Not available today  
 If Yes, specify: Test Name \_\_\_\_\_, results  Normal  Abnormal  Not available today  
 If Yes, specify: Test Name \_\_\_\_\_, results  Normal  Abnormal  Not available today

**Does the patient show evidence of child abuse (physically/ sexual/ psychological)? If yes, specify:**

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**Is there any apparent problems in the areas of developmental level, speech, behavior, or emotional difficulties?  
If yes, specify:**

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**Diagnosis impression and comments:**

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**Treatment recommended, if any:**

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**Next appointment date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Purpose:** \_\_\_\_\_

\_\_\_\_\_  
Signature – Physician