12/2013

EN104

CPCD
giving children a head start

Physical Examination Form

CHILD'S NAME:_____ Birth date:_____ M___ F___ Date Screened:_____

Insurance: ___ Medicaid ___ Private ___ CHP+ ___ Tricare ___ No insurance

PARENT/GUARDIAN NAME	PHYSICIAN NAME

ACUTE/CHRONIC HEALTH ISSUES: (Check all that apply)

	Anemia		Ear Infections		Heart Problem		Serious Illness
	Asthma		Eczema		Hospitalization		Sickle Cell Anemia
	Bowel/Bladder Problems		Epilepsy/Seizure Disorder		Hyperactivity		Vision Problems
	Diabetes		Trouble Hearing		Learning Difficulties		Other

Explain:

Allergies:	**Medications:**

SCREENING Tests	**Results**	Other Tests (if indicated)	**Results**
Hearing -- R / L Vision -- Acuity, R / L.		TB..... Sickle Cell..... Urinalysis……	
Height		**HCT / HGB******** (Required) **Lead Level******** (Required)	
Weight			
Blood Pressure			

PHYSICAL ASSESSMENT	**Normal**	**Abnormal**	**Not Evaluated**	**Comments**
1. GENERAL APPEARANCE				
2. NEUROLOGIC STATUS				
3. SPEECH				
4. SKIN				
5. HEAD				
6. EYES				
7. EARS				
8. NOSE, MOUTH, PHARYNX				
9. TEETH				
10. HEART				
11. LUNGS				
12. ABDOMEN				
13. GENITALIA				

Signature:_____ Title:_____ Date:_____