

PEDIATRIC PHYSICAL EXAM

Date: _____ Telephone: _____

AGE	HT	WT	<input type="checkbox"/> M <input type="checkbox"/> F	HC (Birth to 2 yrs.)	TEMP	P	R	BP (3 yrs & Up)	HEALTH QUESTIONNAIRE REVIEWED AND SIGNED <input type="checkbox"/>	WIC PROGRAM <input type="checkbox"/> YES <input type="checkbox"/> NO	
ALLERGIES:			MEDICATIONS:			IMMUNIZATION REACTION: <input type="checkbox"/> NONE			NUTRITION: (AMOUNT)		
CHIEF COMPLAINTS: (Nursing Staff Notes): PROVIDER NOTES:									Breast _____ Bread/Cereal _____ Juice _____		
									Formula (Fe) _____ Meat/Bean _____ Veggies _____		
									Sweet/Fat _____ Fruit _____ Fast Food _____		
									Milk _____ Dairy Product _____		
									Food Allergy: _____		

TB RISK ASSESSMENT:											
SUBJECTIVE HISTORY		LEGEND <input checked="" type="checkbox"/> = NORMAL		DENTAL (1yr & Up) <input type="checkbox"/> LAST DENTAL CHECKUP			<input type="checkbox"/> DEV. FORM COMPLETED <input type="checkbox"/> ANTICIPATORY GUIDANCE		NURSING STAFF SIGNATURE:		

- Development/School _____
- Elimination _____
- Sleeping _____
- Behavior _____
- Problems _____
- Social _____

VISION

Right _____
 Left _____
 Both _____

No Glasses
 Glasses
 Grossly Normal

OBJECTIVE: PHYSICAL EXAM

- Wt _____ % Ht _____ % HC _____ %
- Nutrition _____
 - Skin _____
 - Head _____
 - Eyes _____
 - Ears _____
 - Nose _____
 - Throat _____
 - Dental _____
 - Neck _____
 - Chest _____
 - Breast _____
 - Lungs _____
 - Heart _____
 - Abdomen _____
 - Extremities _____
 - Hips _____
 - Back _____
 - Neuro _____
 - Gyn/G.U _____
 - Ano-Rectal _____
 - Other _____

URINALYSIS

Color _____
 Clarity _____
 Leukocytes _____
 Nitrite _____
 Urobil _____
 Protein _____
 PH _____
 Blood _____
 Specific Grav. _____
 Ketones _____
 Bilirubin _____
 Glucose _____

ASSESSMENT / MANAGEMENT

- PLANS:**
1. Hemoglobin Lead Level Wellness Profile _____
 2. Counseling: _____

AUDIOMETRY

RIGHT LEFT

500							
1000							
2000							
4000							
<input type="checkbox"/> Grossly Normal							

VACCINE	DOSE	ROUTE	GIVEN BY

Next Physical /WCC is due: _____ Follow-up Appt: _____ PPD Reading Due: _____

Make a future appt for: Nutritionist Dentist Optometrist

PATIENT NAME: _____
 DOB: _____
 MR#: _____

Provider Signature: _____
 Nursing Staff Signature: _____ Date: _____
 INTERPRETER SIGNATURE: _____
 SPAN VIET OTHER N/A HEARING IMPAIRED