

PHYSICAL EXAMINATION FORM

Name: _____ DOB: _____

Date of Exam: _____

Hemoglobin/Hematocrit	Lead:	Height inches	Weight lbs	Blood Pressure:
Urinalysis Results (if indicated)	Vision: L	Developmental Screening:		Hearing:
	R			
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: Extra ocular Movement				
Ears: Canal, tympanic Membrane				
Nose, Mouth, Pharynx, Tonsils				
Teeth				
Heart				
Lungs				
Abdomen (include hernias)				
Genitalia				
Extremities, Feet				
Neurological				
Other:				

Signature of Physician/Health Care Provider

Date