

PHYSICAL EXAMINATION FORM

Name _____

DOB: _____

Date of Exam: _____

Hemoglobin/Hematocrit	Lead:	Height inches	Weight: lbs.	Blood Pressure:
Urinalysis Results (If indicated)	Vision:	Developmental Screening:		Hearing:
	L			
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 _____