

NAME _____

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Strep. Throat
Chicken Pox	German Measles	Mumps	Tonsillitis
Congenital Anomaly	Heart Disease	Operations	Tuberculosis
Convulsions	Hernia	Poliomyelitis	Whooping Cough
Diabetes	Kidney Disease	Rheumatic Fever	Other

PERTINENT FAMILY MEDICAL HISTORY

PHYSICIAN'S EXAMINATION

(O) Normal (X) Abnormal (Comment: Specify consultation requested)

Age _____ BP _____ / _____ Pulse _____ Hgt. _____ Wgt. _____

Physical Development _____

Nutritional Status _____

Skin _____

Eyes _____ Sclera _____ Pupils _____ Light & Distance: r. _____ l. _____ Glasses _____

Ears _____ Canals: r. _____ l. _____
Drums: r. _____ l. _____

Nose _____ Septum _____ Turbinates _____

Mouth _____ Lips _____ Tongue _____

Teeth _____ Gingiva _____

Neck _____ Mobility _____ Lymph nodes _____ Thyroid _____

Throat _____ Shape _____ Symmetry _____

Lungs _____

Heart _____ Rate _____ Rhythm _____ Murmur _____

Abdomen _____ Liver _____ Spleen _____ Hernias _____

Ano-Genital _____ Anus _____ Penis _____ Testicles: r. _____ l. _____
Labia _____

Spine _____

Lower Extremities _____ Range of Motion _____ Development _____ Strength _____

Upper Extremities _____ Range of Motion _____ Development _____ Strength _____

Cranial Nerve _____ I-XII _____ Gait _____ Coordination _____

Date of Exam _____ Physician's Signature _____

Physician's Name _____
Address, Tel. No. _____
(Please Print) _____