PHYSICAL EXAM FORM

Name: _____ Date of Examination: _____

Age: _____ years _____ months

Information to be filled out by physician or other health care provider:

Hemoglobin/Hematocrit:	Lead:	Height: Inches:	Weight: Lbs:	Blood Pressure
Urinalysis Results: (if indicated)	Vision: L R	Developmental Screening:		Hearing:

Does the examination reveal any abnormality:	Normal	Abnormal	Not Examined	Describe fully any abnormal findings.
General appearance, posture, gait.				
Speech/Language Development.				
Behavior During Exam.				
Skin.				
Eyes: Extraocular Movements.				
Ears: Canal, Tympanic Membrane.				
Nose, Mouth, Pharynx, Tonsils.				
Teeth.				
Heart.				
Lungs.				
Abdomen (include hernias).				
Genitalia.				
Extremities, Feet.				
Neurological.				
Other.				

Disability (diagnosed)	Treatment

Summary of findings and recommendations: _____

_____

_____ _____

Signature of Physician or Other Health Care Provider Date

Health Agency Where Examination Completed: _____