Physical Exam Form

Name: ______________________________ Age: _______________

Weight:	Height:	Bloood Pressure:	Urinalysis:	Lead:
Hemoglobin:	Vision Screen: R: L:	Developmental Screening:	Date of Last Physical:	

Does the examination reveal any abnormality?	Normal	Abnormal	Not Examined	Describe 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 (includes hernias)				
Genitalia				
Extremities & Feet				
Neurological				
Other:				
Disability (diagnosed):		Treatment:		

Summary of findings and recommendations:_______________________________________

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_______________________________________ ____________________________

Signature of Physician or Health Care Provider Date

Stamp Here: