NAME ______________________________

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Step. 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

Date______________________ (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.................... trubinates..................

Mouth .... lips .... tongue .... pharynx ....

Teeth................ gingival....................

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.................

______________________________ M.D.
Signature