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WELL CHILD PHYSICAL EXAMINATION

Patient's Name_____ **DOB:**____/____/____ **AGE**____

Yes	No	If yes, explain below
		Asthma
		Kidney, Bladder Disease
		Thyroid problems
		Eye Problem
		Hearing Problems
		Diabetes
		Acid Reflux
		Rheumatic Fever
		Muscular Disease
		Psychiatric Disorder
		Lung or Respiratory problems

Yes	No	If yes, explain below
		Cardiovascular Disease
		Gastrointestinal or Stomach Disease
		Head or spinal injuries
		Seizures, Headaches or Neurological conditions
		Bladder or Urological problems
		Bone problems or Injuries
		Suffering from any other disease
		Permanent defect from illness, disease, or injury
		Current on Immunizations
		Chronic Infections or Tuberculosis
		Surgeries:

Vital Signs: Temp _____F **BP** _____/_____ **Pulse** _____ **Resp** _____ **Height** _____" **Weight** _____

Allergies_____ **Current Medications** _____

Visual Acuity with glasses without R 20 / _____ **L 20 /** _____ **OU** _____ **Color Vision** _____

EXAMINATION Check (✓) is normal or negative. Cross (plus/ +) is significant deviation from normal, details below.

	General Appearance		Thyroid & Neck		Hernia
	Growth/Development		Lymph Glands		Extremities/muscles
	Eye Disease		Chest		Joints
	Ear Disease		Spine		Gait
	Throat & Tonsils		Lungs		Neurological
	Tongue		Heart		Skin
	Teeth & Gums		Abdomen		Other
	Nose & Sinuses		Genitalia		

ASQ-3 Score
O Above Cutoff O Monitor (gray zone) **Return 3 months**
O Below Cutoff (Refer)

M-CHAT Score
O Autism Risk
O Low Risk for Autism

Additional comments:

Clearance: All activities Yes No **Age appropriate counseling, Bright Futures: Yes No**

_____
Providers' Printed Name

_____
Providers' Signature

____/____/____
Date