Physical Examination

Child's Full Name ______________________________

Date of Birth ______________________________ Age ________ Sex ________

PAST HEALTH HISTORY

(to be completed by parent/guardian)

Disease/Condition/Illness	Age Contracted	Comments
Chickenpox (Varicella)		
Whooping Cough		
Measles		
Hay Fever		
Mumps		
Pneumonia		
Scarlet Fever		
Other:		
Other:		

Allergies: ______________________________

Does your child take any continuous medications? ______________________________

Reason for medication(s): ______________________________

Operations: ______________________________

Date(s) of Operation(s): ______________________________

Has your child had a dental screening?

☐ No ☐ Yes Date: ______________________________

Has your child had an eye exam?

☐ No ☐ Yes Date: ______________________________

Has your child has his/her hearing screened (besides at birth)?

☐ No ☐ Yes Date: ______________________________

Continues on Reverse →

My child has problems with…/I am concerned about my child's…

- ☐ Appetite
- ☐ Rest
- ☐ Growth
- ☐ Development, Behavior, & Learning
- ☐ Eyes/Vision
- ☐ Ears/Hearing
- ☐ Toileting
- ☐ Bones/Muscles/Movement/Pain When Moving
- ☐ Nervous System/Twitching/Seizures/Headaches
- ☐ Other: ____________________
- ☐ Nose/Nose Bleeding/Runny Nose
- ☐ Mouth/Gums/Teeth/Mouth Sores/Snoring
- ☐ Frequent Sore Throats/Tonsillitis
- ☐ Breathing Problems/Asthma
- ☐ Heart/Heart Murmur
- ☐ Stomachaches
- ☐ Mobility
- ☐ Language Development (Speech)

Parent/Guardian Signature ______________________________ Date ______________

Parent/Guardian Signature ______________________________ Date ______________

**********MEDICAL EXAMINATION**********

The medical professional may complete any or all of the following screenings that he/she deems necessary for the child at his/her age and/or stage of development.

Height ______________ Weight ______________

General Appearance ____________________ Tonsils & Glands ____________________

Posture ____________________ Heart & Lungs ____________________

Nutrition ____________________ Abdomen ____________________

Skin ____________________ Feet ____________________

Eyes & Ears ____________________ Urinalysis ____________________

Nose & Throat____________________ Blood Count ____________________

Results and recommendations by physician: ____

____

Is the child healthy enough to participate in a preschool program?

______Yes ______No ______Yes with Restrictions:____________________

Signature of Medical Professional ______________________________ Date ______________

Please circle one: MD DO PA ARNP