Children's HOME
Empowering Families • Enriching Communities

Phone: 717-755-1033 Fax: 717-840-3791

MEDICAL EXAMINATION FORM FOR CHILDREN 0-23 MONTHS

NAME: _____ **DOB:** _____

DATE OF EXAM: _____

1. Does the child have a history of any of the following:
    a. Serious illness if so please list_____
    b. Broken bones if so please list_____
    c. Allergies if so please list
    _____
    d. Operations if so please list
    _____
    e. Hospitalizations if so please list_____
2. Does the child take any medication? If so, please list
    _____
3. Last date of: TB Test: _____ DT Booster: _____
    Polio: _____ Rubella Status: _____
    Hep. B: (1) _____ (2)_____ (3)_____Haemophilus
    Influenza Type B (HIB) _____
    Varicella Vaccine (Chicken Pox) _____
4. Review of systems: Temp: _____ Pulse: _____ Respiration_____ B/P: _____

Height: _____Weight: _____lbs. _____oz

Appetite: _____

Oriented to Person: _____ Place_____ Time_____

Race_____ Characteristic Markings:

_____

Eye Color: _____ Hair Color:_____

Hearing:_____

Bruises: _____ Lesions: _____Rash: _____

General Appearance	Normal	Abnormal	Comments
Skin			
HEENT			
Dental			
Neck (Thyroid)			
Lymph Nodes			
Chest (breasts)			
Heart			
Abdomen			
Genitalia/Hernia			
Extremities			
Orthopedic (Spine)			
Neurological			
Mental Status			

GENERAL IMPRESSIONS:

RECOMMENDATIONS:

Physician Signature: _____ Name Printed: _____

Nurse Signature: _____ Name Printed: _____

Date: _____