Children's HOME
Empowering Families • Enriching Communities

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

MEDICAL EXAMINATION FORM
FOR CHILDREN 24 MONTHS AND OLDER

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) _____

   Pap Smear: _____ Date/LMP: _____ Regular _____ Problems _____

   Last Sexual Experience: _____

   Sickle Cell test results: _____ Test date: _____ Conducted by: _____

4. Use of Street Drugs. If so, please list amount used, frequency, withdrawal symptoms:

_____

Use of Alcohol. If so, please list amount, frequency, withdrawal symptoms:

_____

Use of Cigarettes. If so, please list amount and frequency: _____

Use of Birth Control. If so, please list: _____

5. Concern Regarding: Pregnancy? Yes _____ No _____

   Venereal Disease. If so, please explain: _____

6. 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: _____**Audiometer results**: (R) _____ (L) _____

Pass ____ Fail____

Bruises: _____ Lesions: _____ Rash: _____

Visual Acuity: Far (R) _____ (L) _____ Diagnostic only: _____

With/Without Glasses: Near (R) _____ (L) _____ UA _____ HCT _____

Has Glasses: _____ Wears Glasses: _____

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: _____