



# General Physical Form

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Parents'/Guardian's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Name of Practice \_\_\_\_\_ Attending Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Medical History:**

Please indicate yes or no if the child ever had or currently has any of the following. (If you answered "yes" please give approximate dates):

Appendicitis:	Polio:	Bed Wetting:
Asthma:	Rheumatic Fever:	Encopresis:
Chicken Pox:	Scarlet Fever:	Head Injuries:
Diabetes:	Thyroid Disease:	Frequent/sever headaches:
Epilepsy:	Tonsillitis:	VD—syphilis, gonorrhea, etc:
Heart Trouble:	Tuberculosis:	Reaction to medication:
Measles:	Whooping Cough:	Broken bones:
Mumps:	Insomnia:	Blood disorders:
Pneumonia:	Sleep walking:	Attempted suicides:

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physical Evaluation:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Heart Rate \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Respiration \_\_\_\_\_

Does child have current immunization shots?  Yes  No explain: \_\_\_\_\_

TB Test: Date of: \_\_\_\_\_ Date Read: \_\_\_\_\_ Neg: \_\_\_\_\_ Pos: \_\_\_\_\_

Allergies \_\_\_\_\_ Food \_\_\_\_\_ Medication \_\_\_\_\_ Insects \_\_\_\_\_

Chest & Lung \_\_\_\_\_ Abdomen \_\_\_\_\_ Genitalia \_\_\_\_\_

Musculo-skeletal \_\_\_\_\_ Neurological \_\_\_\_\_ DSM Diagnosis \_\_\_\_\_

Skin & Lymph Nodes \_\_\_\_\_ Scabies Pos: \_\_\_\_\_ Neg: \_\_\_\_\_

Vision Test without glasses RT: \_\_\_\_\_ LT: \_\_\_\_\_ With glasses: RT: \_\_\_\_\_ LT: \_\_\_\_\_

Hearing Test \_\_\_\_\_

**Nutritional Assessment:** \_\_\_\_\_

**General Assessment:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_  
**Physician**

\_\_\_\_\_  
**Date**