



PHYSICAL EXAMINATION FORM

____ Initial ____ Annual Date of Exam: _____

Name: _____

DOB: _____ Age: _____ Race: _____ Gender: _____

Exam Purpose: ____ Annual Exam ____ Other: _____

HT: _____ WT: _____ Pulse: _____ BP: _____

Health History

Disabilities, Cognitive or Intellectual Concerns:

Immunizations up to date? ____ YES ____ NO

If no, immunizations needed: _____

Significant Medical History:

Current Medications:

Medication History:

Relevant Family Medical History:

Allergies:

Health Behaviors

Smoking _____ Yes _____ No
If yes, amount: _____

Alcohol Use _____ Yes _____ No
If yes, amount & frequency: _____

Exercise _____ Yes _____ No
If yes, amount & frequency: _____

Diet restrictions _____ Yes _____ No
If yes, describe: _____

Sexually Active _____ Yes _____ No
If yes, is youth using birth control: _____ Yes _____ No
If yes, is youth pregnant: _____ Yes _____ No
If yes, does youth have a known STD _____ Yes _____ No

Physical/Developmental Disabilities _____ Yes _____ No
If yes, describe: _____

Social History

Psychosocial Concerns:

History of Abuse or Neglect _____ Yes _____ No
If yes, describe:

History of Pregnancy _____ Yes _____ No
If yes, describe circumstances and outcome: _____

Physical Exam:

Vision:

