A Second Chance, Inc.
Physical Examination Form

Child's Name:	Sex [ ] F [ ] M	D.O.B.
Physician's Name:		
Physician's Address:		
Physician's phone	Physician's Fax Number:	
Date of Exam:		
Reason for visit: [ ] EPSDT Screening [ ] Well Child Care Visit		

Weight Kg. | Lb.	Height Cm. | In.	Temp |	Pulse:	Resp:	Blood Pressure

	Normal	Abnormal
1. Eyes	☐	☐
2. Ears	☐	☐
3. Nose / Sinus	☐	☐
4. Neck / Thyroid	☐	☐
5. Chest	☐	☐
6. Breast	☐	☐
7. Female	☐	☐
Tanner Stage: _____		
Male		
8. Thorax	☐	☐
9. Lungs	☐	☐
Cardiovascular		
10. Heart	☐	☐
11. Radial Pulse	☐	☐
12. Femoral Pulse	☐	☐
13. Pedal Pulse	☐	☐
14. Blood Pressure	☐	☐
Abdomen / Pelvis		
15. General	☐	☐
16. Liver	☐	☐
17. Kidney	☐	☐
18. Spleen	☐	☐
19. Groin	☐	☐
20. Anal / Rectal	☐	☐
Musculoskeletal		
21. Extremities	☐	☐
22. Back / Spine	☐	☐
Neurological		
Motor Functions		
23. Sensory Exam	☐	☐

	Normal	Abnormal
24. Speech	☐	☐
25. Balance	☐	☐
General		
26. Nutrition	☐	☐
27. Appearance	☐	☐
28. Posture	☐	☐
29. Self-Image	☐	☐
30. Temperament	☐	☐
31. Behavior	☐	☐
Female Genitalia		
32. Labia	☐	☐
33. Vagina	☐	☐
34. Uterus	☐	☐
35. Ovaries	☐	☐
36. Urethra	☐	☐
Tanner Stage: _____		
Male Genitalia		
37. Penis	☐	☐
38. Testes	☐	☐
39. Scrotum	☐	☐

Vision Screen
Without Corrections RT. 20/ LT. 20/
With Corrections RT. 20/ LT. 20/

Audio Screen						
	1000	2000	3000	4000	6000	8000
RT.						
LT.						

Urine Screen					
SP. GR.	Ph.	Protein	Glucose	Ketones	Blood
HGB/HCT _____	Lead _____	Sickle Cell _____		CBC _____	

Immunizations / Vaccine Administration

Ages:	Date Given	Dosage	Route & site given	Signature of Vaccine Administrator
Birth				
HEP-B				
HEP-B (1 Month)				
2 Months				
DTP				
HIB				
OPY Polio (oral)				
4 Months				
DTP				
HIB				
OPY Polio (oral)				
6 Months				
HEP-B				
DTP				
HIB				
MMR				
CHICKEN POX				
VARICELLA				
4-6 Years				
DTP				
OPV Polio (oral) MMR may be given 4-6 years or 11-12 years				
11-12 Years				
If child did not get HEP-B series from birth to 6 months all teens need HEP-B 14-16 shots				
14-16 Years				
DT and not Petussis				

Additional Comments:

_____

_____

Physician Signature: _____

Physician I.D. Number: _____

Date: _____