MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

Pediatric/Adolescent Physical Exam

OTSG APPROVED (Date)

Address	Telephone	Birthdate	Age
	School		

Activities: ☐ Boy Scouts ☐ Girl Scouts ☐ Camp ☐ Preschool ☐ Youth Activities

Part II - Past Illnesses and Approximate Dates

If "YES" is checked, add approximate date(s).

	YES	NO	DATE
Frequent colds	☐	☐	______
Sore Throat	☐	☐	______
Ear Infection	☐	☐	______
Bronchitis	☐	☐	______
Asthma	☐	☐	______
Allergy	☐	☐	______
Operations	☐	☐	______
Injury	☐	☐	______
Upset Stomach	☐	☐	______
Kidney trouble	☐	☐	______
Heart trouble	☐	☐	______
Rheumatic Fever	☐	☐	______
Convulsions	☐	☐	______
Missing organs	☐	☐	______
Diabetes	☐	☐	______
Head injury	☐	☐	______
Other illness (Specify)	☐	☐	______

Medications/
Allergies:

Part III - Physical Examination

Date	Height (in)	Weight (lb)	BP
Pulse	Vision R 20/ L 20/	With Glasses ☐	Without Glasses ☐

Build: Endomorph Mesomorph Ectomorph Obese

	Normal	Abnormal	Comments
Eyes - PERRLA, EOM's intact	☐	☐	______
Ears - TM's Clear	☐	☐	______
Nose - Clear, No Purulent Discharge	☐	☐	______
Throat - OP Clear, No Exudate, No Erythema	☐	☐	______
Teeth - Good Dentition Braces present/not present	☐	☐	______
Thyroid - No Thyromegaly, no masses appreciated	☐	☐	______
Heart - RRR S1 S2; No m/r/g appreciated	☐	☐	______
Lungs - CTA Bilaterally, no crackles, no wheezing, no rhonci	☐	☐	______
Abdomen - +soft, +BS, NT, ND, No HSM appreciated	☐	☐	______
Hernia - Non appreciated, Umbilical or Inguinal	☐	☐	______
Genitalia - Normal Male, testes descended OR Normal Female, external genitalia	☐	☐	______
Skin - Normal, no rashes	☐	☐	______
Extremities - FROM	☐	☐	______
Back - Straight	☐	☐	______
Neurological - Normal Development	☐	☐	______
Muscles/Strength - Normal 5/5, BUE, LUE	☐	☐	______
Tanner Stage - Normal Development	☐	☐	______
Other	☐	☐	______

Does your child's behavior trouble you? ____ YES ____ NO

Does your child's progress in school trouble you?

Comments:

Impression:

Recommendations (Medical or Dental consultation, medications, rest period, special education, etc.): YES NO

___ Full participation in school/sports activities/daycare/camp

___ Limited participation in school/sports activities/daycare/camp

(Continue of reverse)

PREPARED BY (SIGNATURE & TITLE)	DEPARTMENT/SERVICE/CLINI **PRIMARY CARE CLINIC/PEDIATRICS**	DATE (YYYYMMDD)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (SPECIFY)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT