PAC PHYSICAL EXAMINATION FORM

DATE OF PHYSICAL: ___/___/____

Child's Name:_______________________________ Medical Provider:___________________________ Address: ____________________________________	DOB: ______________ Sex: __Male __ Female Phone: ______________________________ Fax: ________________________________

TPR	BLOOD PRESSURE	HEIGHT	WEIGHT/BMI	VISION SCREENING
P- R- T-			WT- BMI -	FAR: RT20/___ LT20/___ BOTH: ________

WNL= Within Normal Limits ABN= Abnormality Description	DIRECTIONS: 1. Check if WNL or ABN 2. Describe each ABN at bottom

HEALTH HISTORY	
Allergies	
Hospital/Surgery	
PMH	
Psychiatric Admissions	
Tobacco	
Drugs	
Alcohol	

PRESCRIBED MEDICATIONS	DOSAGES

S/S of Contagious Disease: ________________________

Is the child free from communicable disease? Yes / No

WNL	CHECK EACH ITEM IN WNL OR ABN COLUMN – LEAVE NO BLANKS	ABN
	1. General Description	
	2. Head	
	3. Eyes	
	4. Ears/Gross Hearing	
	5. Nose	
	6. Mouth and Throat	
	7. Neck	
	8. Chest	
	9. Breast (female) Gynescomastia (male)	
	10. Heart	
	11. Abdomen	
	12. Genitalia	
	13. Anus and Rectum	
	14. Back	
	15. Extremities	
	16. Skin	
	17. Neurological	
	18. Lymph Nodes	

___ Cleared for activity without restriction
___ Full Body Assessment Completed
___ Accepts STD Screen ___ Declines STD Screen
___ No complaints ___ See below

Any screening tests or laboratory as indicated by the physician, please list below: ____________
____
____

Description of Abnormalities (If needed): ____
____

Print Name and Title of Examiner: ____________________________________
Signature and Title of Examiner: _____________________________________