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

The proponent agency is MAHC DFM-PC

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:

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

Part III - Physical Examination

Date	Height (in)	Weight (lb)	BP

Pulse	Vision		With Glasses ☐
	R 20/	L 20/	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 progress in school trouble you? ☐ YES ☐ NO

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
- ☐ Cardiovascular screen completed? ☐ Yes ☐ No
  If done, is further action required? ☐ Yes ☐ No

(Continue of reverse)

PREPARED BY (SIGNATURE & TITLE) | DEPARTMENT/SERVICE/CLINIC: DEPARTMENT OF FAMILY MEDICINE/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