BORDENTOWN REGIONAL HEALTH SERVICES

History and Physical Examination to be Completed by the Health Care Provider

Last Name:_____ First Name:_____

Date of Birth:_____ Gender:_____

Medical History

Apgar Scores: 1 minute_____ 5 minute_____ Gestation: _____ weeks

Prenatal problems:_____

Disease History (please indicate dates)

Allergies_____ Asthma_____ Otis Media_____

Drug Sensitivities_____ Asthma Action Plan: ___yes ____no Rheumatic Fever_____

Lyme Disease_____ Convulsive Disorder_____ Strep Infections_____

Hepatitis_____ Diabetes_____ Mononucleosis_____

Neuromuscular Disorder_____ Heart Disease_____ Heart Murmur_____

Heart Defect_____ Cancer_____ Seizures_____

Chicken Pox_____ Congenital Anomalies_____ Scarlet Fever_____

Pneumonia_____ Other_____

Surgical Procedures (please indicate dates):_____

_____

Is this child receiving any medications? _____

Does this child have any physical needs or restrictions that would prevent or limit participation in school activities, including gym and sports activities? _____No _____Yes

Please Describe _____

Immunization History

Please indicate the appropriate month, date and year immunizations were administered.

Vaccine Type	1st Dose	2nd Dose	3rd Dose	4th Dose	5th Dose
DPT, DT or Dtap					
OPV or IPV					
MMR					
HIB					
Hepatitis B					
Varicella					
Pneumococcal*					
Influenza*					
Other:					

*Required for Preschool Students only

Tuberculosis testing: Mantoux testing Date_____ Results_____

Chest X-Ray: Date_____ Results_____ INH therapy date started_____

Physical Examination

Height_____ Weight_____ Blood Pressure_____

Eyes _____ Ears_____

Nose _____ Mouth and Teeth _____

Throat_____ Tonsils/Adenoids _____

Lymph glands_____ Skin_____

Heart_____

Murmur?_____ Functional _____ Pathologic_____

Any Restrictions? _____

Lungs _____

Musculoskeletal _____ Scoliosis _____

Abdomen _____ GI/GU _____

Hernia_____ Nervous System _____

Speech _____

Growth and Development _____

Previous serious injuries, illness or deformities (please describe) _____

_____

Hearing Results

Db Level _____ For each frequency, please indicate: P=Pass F=Fail

	500Hz	1000Hz	2000Hz	3000Hz	4000Hz
Right:	_____	_____	_____	_____	_____
Left:	_____	_____	_____	_____	_____

Conclusion: (Please circle one): Pass Fail

Referral made for further testing: (Please circle one): Y N

Comments: _____

_____

Vision Results

Right: 20 / _____ Left: 20 / _____ Both: 20 / _____

If vision screening over 20/32, was referral made: (Please circle one) Y N

Physician's Signature_____ Date of Exam_____

Office Stamp: