

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 <input type="checkbox"/> Boy Scouts <input type="checkbox"/> Girl Scouts <input type="checkbox"/> Camp <input type="checkbox"/> Preschool <input type="checkbox"/> Youth Activities			
Part II - Past Illnesses and Approximate Dates		Part III - Physical Examination	
If "YES" is checked, add approximate date(s).		Date	Height (in)
		Weight (lb)	BP
		Pulse	Vision
		R 20/	L 20/
		With Glasses	
		Without Glasses	
		Build	Endomorph <input type="checkbox"/> Mesomorph <input type="checkbox"/> Ectomorph <input type="checkbox"/> Obese <input type="checkbox"/>
		Normal Abnormal Comments	
Frequent colds	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE	Eyes - PERRLA, EOM's intact <input type="checkbox"/> <input type="checkbox"/>
Sore Throat	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Ears - TM's Clear <input type="checkbox"/> <input type="checkbox"/>
Ear Infection	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Nose - Clear, No Purulent Discharge <input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Throat - OP Clear, No Exudate, No Erythema <input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Teeth - Good Dentition <input type="checkbox"/> <input type="checkbox"/>
Allergy	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Braces present/not present <input type="checkbox"/> <input type="checkbox"/>
Operations	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Thyroid - No Thyromegaly, no masses appreciated <input type="checkbox"/> <input type="checkbox"/>
Injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Heart - RRR S1 S2; No m/r/g appreciated <input type="checkbox"/> <input type="checkbox"/>
Upset Stomach	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Lungs - CTA Bilaterally, no crackles, no wheezing, no rhonci <input type="checkbox"/> <input type="checkbox"/>
Kidney trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Abdomen - +soft, +BS, NT, ND, No HSM appreciated <input type="checkbox"/> <input type="checkbox"/>
Heart trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Hernia - Non appreciated, Umbilical or Inguinal <input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Genitalia - Normal Male, testes descended OR Normal Female, external genitalia <input type="checkbox"/> <input type="checkbox"/>
Convulsions	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Skin - Normal, no rashes <input type="checkbox"/> <input type="checkbox"/>
Missing organs	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Extremities - FROM <input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Back - Straight <input type="checkbox"/> <input type="checkbox"/>
Head injury	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Neurological - Normal Development <input type="checkbox"/> <input type="checkbox"/>
Other illness (Specify)	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	Muscles/Strength - Normal 5/5, BUE, LUE <input type="checkbox"/> <input type="checkbox"/>
Medications/ Allergies:		Tanner Stage - Normal Development <input type="checkbox"/> <input type="checkbox"/>	
Does your child's behavior trouble you? <input type="checkbox"/> YES <input type="checkbox"/> NO		Does your child's progress in school trouble you? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Comments:			
Impression:			
Recommendations (Medical or Dental consultation, medications, rest period, special education, etc.): <input type="checkbox"/> YES <input type="checkbox"/> NO			
<input type="checkbox"/> Full participation in school/sports activities/daycare/camp <input type="checkbox"/> Limited participation in school/sports activities/daycare/camp <input type="checkbox"/> Cardiovascular screen completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If done, is further action required? <input type="checkbox"/> Yes <input type="checkbox"/> No			
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)		<input type="checkbox"/> HISTORY/PHYSICAL <input type="checkbox"/> FLOW CHART <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> DIAGNOSTIC STUDIES <input type="checkbox"/> TREATMENT	