



House of New Hope
8135 Mt. Vernon Rd. St. Louisville, Ohio 43071
Tel: (888) 200-1296 Fax: (740) 745-3429

Physical Examination

(Physical Examination required every 12 months)

Date of Exam: _____

Child's Name: _____

Date of Birth: _____

Height _____ Weight _____ Temp _____ BP _____ Pulse _____
Resp _____

General: _____

Skin/Scalp: _____

Head: _____

Eyes: _____

Vision Screen: Right Left Both

Is visual analysis necessary? _____

Ears: _____

Nose: _____

Mouth/Throat: _____

Neck: _____

Adenopathy: _____

Chest and Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Neurological and Reflexes: _____

TB Tine Test / Date _____ Positive _____ Negative _____

Urinalysis Results: _____ Date _____

Hematocrit Results: _____ Date _____

CBC Results: _____ Date _____

Allergies: _____

Current Medication (Prescribed and OTC):

Medication History:

Immunization(s): *Please review and update as available*

_____ Date _____

_____ Date _____

_____ Date _____

Are Immunizations Record Complete? _____ No _____ Yes

Abnormal Findings from Physical Exam

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Physician Recommendations

Print or Type

Physician's Name: _____

Office Address: _____

City/State/Zip _____

Telephone _____ Fax _____

Physician's Signature _____