

# PHYSICAL ASSESSMENT

To Be Completed by Physician, Nurse, School Health Professional or Child Care Professional

## REQUIRED

	NL	AB NL	COMMENTS	LABORATORY (AS INDICATED)		
				DATE	NL	COMMENTS
BP: WT:                    HT:				Hemoglobin		
				Hematocrit		
SKIN: Color, Rash, Swelling, Hair, Nails				Urinalysis		
				Other		
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement				Medications:		
EARS: Pinnae, Canals; Tympanic Membrane Appearance, Mobility						
NOSE: Nares, Turbinates				Diet Restrictions:		
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx						
NECK: Thyroid, Range of Motion				Special Equipment:		
NODES: Cervical, Axillary, Inguinal, Other						
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses				Allergies:		
LUNGS: Rate, Auscultation, Percussion						
ABDOMEN: contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness				General Comments/Recommendations		
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia						
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine Curvature						
NEUROLOGICAL: Gair, Cerebellar Function, Motor System (Strength, Tone); Cranial Nerves (Gross)						
DEVELOPMENTAL:						
Gross Motor						
Fine Motor						
Social						
Speech/Language						

I have performed a physical assessment on this child on \_\_\_\_\_ and have arranged for any follow-up that was or is needed. Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_