Family Physician's Physical Examination Report

Name_____ Date of Birth_____
Date of Exam_____ Grade_____
***Note**: If normal, mark "N" – If any abnormalities, please state nature of such.*

Eyes_____ Genito Urinary_____
Ears_____ Orthopedic:_____
Lymph Nodes_____ Structural_____
Thyroid_____ Posture_____
Nose_____ Feet_____
Tonsils_____ Skin_____
Teeth_____ Epilepsy_____
Heart_____ Speech_____
Lungs_____ Nutrition_____
Hernia_____ Other_____

Immunizations

Mumps_____ Cold & Flu Shots_____
Diptheria_____ Measles Vaccine_____
Poliomyelitis_____ Rubella Vaccine_____
Tetanus_____ Others_____
Booster

Allergies to Medicines:_____
Other Allergies:_____
Existing Medical Condition(s):_____
Restrictions/Limitations:_____
Special Needs/Diets:_____
Medication/Treatment:_____
Other Concerns (i.e., bed wetting, sleep walking, etc.):_____

Physician's Signature_____
Physician's Phone Number_____
Date_____