

Medical Evaluation Record

Child's Name: (First) (Middle) (Last) Birthdate:

Present Illnesses/Reason for Visit: Medicaid #

PHYSICAL EXAMINATION:

Ht.....Wt.....
 B.P...../
 Temperature.....
 Skin:.....
 PPD/TB Skin Test:.....
 Scalp:.....
 Ears:.....
 Hearing:
 Right..... Left.....
 Eyes, Pupillary React:.....
 Vision (R) 20/..... Corr. 20.....
 (L) 20/..... Corr. 20.....
 Eye Glasses:.....
 Date Prescribed:.....
 Glands/Lymphalus.....
 Heart: Rate..... Murmurs.....
 Lungs:.....
 Abdomen:.....
 Genitalia:.....
 Hernia.....
 Musculoskeletal:
 Up. Extremities:.....
 Lo. Extremities:.....
 Spine:.....
 Reflexes:.....
 Posture:.....
 Neurologic:.....
 Congenital Defects:.....
 General Condition:.....

LAB FINDINGS:

HGB/HCT.....
 Urinalysis:
 Specific gravity..... Protein.....
 Glucose..... Blood.....
 Other.....

RADIOLOGICAL STUDIES:

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CHILD'S HEALTH HISTORY:

Chickenpox:..... Asthma:..... Seizures:.....
 Hospitalizations:.....
 Operations:.....
 Significant Injuries:.....
 Developmental Milestones:(i.e. walking, talking, toilet training,etc.)

 Birth/Delivery:(i.e. complications, natural, c-section,etc.)

 Allergies: (i.e. medication, food, etc.)

 Sexual Activity:.....
 Substance Use:.....
 Significant Problems with Daily Living Activities:

 Other:.....

BIRTH FAMILY SIGNIFICANT HEALTH HISTORY:

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IMMUNIZATIONS:

VACCINE:	DATE GIVEN:
Hep-B (Hepatitis B)
DTaP/Td (Diphtheria, Tetanus & Pertussis)
Hib (H.Influenzae, type B)
Polio
MMR (Measles, Mumps & Rubella)
Chicken Pox
Prenvar
Other.....
Immunizations Due:.....

IMPRESSIONS/TREATMENT PLAN/RECOMMENDATIONS:.....

REFERRALS:.....

EXAM COMPLETED BY:.....

SIGNATURE

TITLE

DATE:.....

ADDRESS:.....

PHONE #:.....