Annual Physical Exam Report

Physician Name:___________________________________ **Date of Exam:**________________

Name	Date of Birth	Age	Gender ☐Female ☐Male

Vital Signs: HR____ RR____ BP____ Temp.____ Growth: Weight _____ lbs. _____ %

Height: _____inches ____ %

Review and Description of Systems (Please note pertinent findings)

General	☐fatigue ☐fever ☐weight loss ☐diaphoresis
Skin	☐persistent rash/spots ☐acne ☐tattoos
HEENT	☐headache ☐TMJ pain ☐visual/hearing problems ☐rhinitis ☐sore throat ☐frequent nosebleeds
Neck	☐masses
Chest	☐chronic cough ☐wheezing ☐DOE ☐chest pain ☐breast lumps/discharge
CVS	☐murmurs ☐HTN ☐palpitations
GI	☐abdominal pain ☐vomiting ☐diarrhea/constipation ☐jaundice ☐food intolerance
GYN	☐cycle length ☐flow ☐dysmenorrhea ☐vaginal discharge ☐dyspareunia
GU	☐dysuria ☐discharge ☐scrotal masses ☐urinary frequency ☐incontinence ☐enuresis
CNS	☐fainting ☐LOC ☐weakness ☐tremor ☐seizures
Muscles-skeletal	☐scoliosis ☐joint aches/swelling ☐recent trauma ☐limp ☐sport injury
Nutrition	☐usual eating habits ☐currently dieting binges ☐diet pills ☐body image
Psychiatric	☐depression ☐suicide contemplated/attempted ☐hallucinations ☐previous psychological

Screening Tests | **Risk-Based Lab Tests**

	Yes	No	Results		Yes	No	Results
Hearing				Venereal Warts			
Vision				Cultures for STDs			
Lead Poisoning				Blood test for STDs			
Hemoglobin/ Hematocrit				Hepatitis screen			
Urine Analysis				Tuberculosis			
Other:				Other:			

Current medication and changes in medication:

Follow-up Tasks/Issues for Next Visit | **Referrals**

Preventive Care:	**Acute Care:**	
Chronic Care:	**Emotional Behavioral Conditions:**	

Over-the-Counter Medications
Physician Approval

By signing below, I authorize the foster parents of the above-named child to administer the following over-the-counter medications to the child as needed:

- Ibuprofen/Motrin/Advil
- Tylenol/Acetaminophen
- Vitamins
- Stomach Remedies
- Cold/Flu Medications
- Allergy Medications
- Herbal Remedies
- Menstrual Medication
- Other ____________________

Physician's Signature ____ **Date** _______________________