 El Paso County Department of Human Services

Initial Physical Examination Form

Must be completed and turned in to the child's caseworker within 14 days of the appointment.

Childs Name_______________ **Sex** _______ **Date of Birth** _______________

Date Appointment Made_______________ **Date of Examination** _______________

Height _______ Weight _______ Temperature _______

Skin _______________

Scalp _______________

Eyes - Papillary Reaction **Vision without glasses** Right _______ Left _______

Vision with glasses Right _______ Left _______

Ears - Otoscopic **Hearing** Right _______ Left _______

Nose _______________

Teeth - Number _______ Condition _______ Occlusion _______

Throat - Pharynx _______ Tonsils _______

Adenoids _______ Glands _______

Thyroid _______ Chest _______

Heart _______ Lungs _______

Abdomen _______________

Secondary Sex Characteristics _______ Genitals _______

Reflexes _______ Extremities _______

Posture and Spine _______________

Nutrition _______________

Signs of Endocrine Imbalance _______________

Menses _______________

Blood Pressure: (1) Normal _______ (2) Abnormal _______ (3) Vasomotor Stability _______

Treatment given: _______________

____

Recommendations: _______________

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Examining physician's signature _______________

Please print or type Physician's name, complete address and phone number

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NOTE: If more space is needed, please use back side of this sheet.