

CHOICES FOR LIFE

Assessment | Medical Examination Report for Treatment Parent Specialist

_____	_____	_____	_____
Name	Birthdate	Height	Weight
_____		_____	
Address		County	

GENERAL PHYSICAL EXAMINATION - REPORT OF FINDINGS:

(To be completed by a physician)

Check Below if Normal

_____	Eyes	Any evidence of disease or disorder not correctable by glasses or contacts
_____	Ears	Any evidence of deafness or other disease
_____	Heart	Enlargement, thrill, murmurs, rhythm
		Blood _____ Systolic _____
		Pressure _____ Diastolic _____
		Pulse Rate _____ EKG _____
_____	Lungs	Any evidence of abnormality by history or physical
_____	Abdomen	Any evidence of abnormality by history or physical
_____	Nervous System	Any history of illness related to the nervous system
_____	VDRL	Attach report, if indicated
_____	Urine	Attach report, if indicated
_____	TB Result	

MEDICAL HISTORY:

List any communicable, hereditary or debilitating diseases, especially psychoneurotic disorders, epilepsy, fainting spells or operations. Is the patient on any medications?

Over what period of time have you known the patient professionally?

Does the patient have any condition that would impair ability to care for children?

COMMENT OF PHYSICIAN: (Regarding patient's emotional, intellectual and physical health)

Physician's Signature: _____ Date: _____

Address _____ Telephone No: _____