Fernald Medical Monitoring Program for Children

Physician's History and Physical Exam

HISTORY

Date ____________________    Birth Date ____________________

Taken by: ____________________

Given by: ____________________    Relationship: ________________

I. Present Symptoms:

II. Past Medical History:

A. Birth:

1. Place: ____________________
2. Duration of Pregnancy: ____________________
3. Delivery: ____________________
4. Apgars: ____________________
5. Birth weight: ____________________
6. Maternal History/Drugs: ____________________

7. Neonatal History: ____________________

B. Developmental:

1. Sat alone: ____________________
2. Crawled: ____________________
3. Walked unsupported: ____________________
4. First word: ____________________
5. First phrase: ____________________
6. Toilet trained: ____________________
7. Speech problems: ____________________
8. School:
   a. Grade ____________________
   b. Sports (type) ____________________
C. Medical:

1. Dietary: breast ____ formula ____ vitamins ____ iron ____ fluoride ____

2. Allergies: YES ____ NO ____ ________________

3. Medication: ________________

4. Anesthesia/Transfusion: YES ____ NO ____

5. Hospitalization/Surgery: YES ____ NO ____
   Diagnosis/Place/Date: ________________

6. Contagious/Other Illnesses:
   Varicella ____ Mumps ____
   Rubella ____ Scarlet Fever ____
   Rubeola ____ Rheumatic Fever ____
   Herpes Zoster ____ OTHER ________________

D. Environmental/Social:

1. Type of dwelling: ________________
2. Type of water: city ____ cistern ____ other ____
3. Type of heat: forced gas ____ electric ____
   hot water ____ solar ____ other ____
4. Number of occupants of dwelling: ________________
5. Pets: ________________
6. Father's occupation: ________________
7. Mother's occupation: ________________
8. Other: ________________
III. Family History:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>Weight</th>
<th>Height</th>
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</thead>
<tbody>
<tr>
<td>Mother</td>
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<td>Father</td>
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<tr>
<td>Siblings</td>
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Illnesses (note relative affected)

Allergies: ____________________________
Anemia/Bleeding: ______________________
Arthritis: ___________________________
Congenital Defects: ___________________
Cancer: ______________________________
Convulsions: _________________________
Diabetes Mellitus: ____________________
Gastrointestinal: ____________________
Cardiovascular/Hypertension: _________
Lungs/Tuberculosis: _________________
Migraine: ___________________________
Renal: ______________________________
Thyroid/Other Endocrine: _____________
Vision/Hearing: _________________
Other: _______________________________

Comments on Family Illnesses: ____________________________

IV. Immunization (Review in Questionnaire):

1. Complete and current _______________

2. Needs: ____________________________
### Review of Systems

<table>
<thead>
<tr>
<th>Area</th>
<th>YES</th>
<th>NO</th>
<th>Comment on &quot;YES&quot; Answers</th>
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<tbody>
<tr>
<td><strong>General</strong></td>
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<tr>
<td>Excessive tiredness</td>
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<td>Poor sleeper</td>
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<td>Other</td>
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<tr>
<td><strong>Head and Neck</strong></td>
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<tr>
<td>Headaches</td>
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<td>Neck pain</td>
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<td>Neck swelling</td>
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<td>Lumps</td>
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<td>Other</td>
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<tr>
<td><strong>Eyes</strong></td>
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<td>Strabismus</td>
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<td>Glasses</td>
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<td>Blurring</td>
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<td>Double vision</td>
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<td>Pain/itch/watery</td>
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<td>Other</td>
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<tr>
<td><strong>Ears</strong></td>
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<td>Hearing problems</td>
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<td>Ear infections</td>
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<td>Dizziness</td>
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<td>Other</td>
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<td><strong>Nose</strong></td>
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<td>Itching</td>
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<td><strong>Mouth</strong></td>
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<td>Teeth problems</td>
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<td>Hoarseness</td>
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<td>Mouth ulcers</td>
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<td>Pharyngotonsillitis</td>
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<td><strong>Respiratory and Cardiovascular</strong></td>
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<td>Cough</td>
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<td>Short of breath</td>
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<td>Chest pain</td>
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<td>Palpitations</td>
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<td>Symptom</td>
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<td>Gastrointestinal</td>
<td>Abdominal pain</td>
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<td>Nausea/ vomiting</td>
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<td>Constipation/ diarrhea</td>
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<td>Poor appetite</td>
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<td>Bleeding</td>
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<td>Lump in breasts</td>
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<td>Hernia</td>
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<td>Other</td>
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<td>Joint pain</td>
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<td>Skin</td>
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<td>Other</td>
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Physical Examination

Age _____ Sex _____

Vital Signs

Weight _____ Height _____ B.P. _____

Temp _____ Cardiac Rate _____ (Regular ____ Irregular ____)

Check and/or complete appropriate space.

General

_____ Well developed and nourished child without any apparent abnormality.

_____ Abnormal appearance (describe) __________________________________________

______________________________________________

Skin

_____ Normal _____ Bruising _____ Simean crease

_____ Pale _____ Petechiae _____ Rash

_____ Cyanosis _____ Cafe' au lait _____ Webbing

_____ Jaundice _____ Hemangioma _____ Other

______________________________________________

______________________________________________

Head

_____ Normal

_____ Abnormal size/shape (describe) __________________________________________

_____ Abnormal facies (describe) ______________________________________________

_____ Other

______________________________________________

______________________________________________
Eyes/Vision

Eyes

___ Normal extraocular muscles
___ Strabismus (describe)     ____________________________
___ Epicanthal fold ____________________________
___ Hypertelorism       ___ Hypertelorism
___ Normal fundoscopic exam
___ Abnormal fundoscopic exam (describe)

___ Other ________________________________________

Vision

Visual acuity: ___ corrected  ___ uncorrected
(snellen chart)
  Right ______/_____
  Left ______/_____

Ears/Hearing

Ears

___ Normal ears
___ Abnormal position (describe) ____________________________
___ Abnormal form (describe) ____________________________
___ Skin tags __________________________________________
___ Preauricular sinus ____________________________
___ Other ________________________________________

Hearing

___ Normal hearing
___ Abnormal hearing (describe) ____________________________

Nose/Sinuses

___ Normal nose and sinuses
___ Deviated septum (describe) ____________________________
___ Other ________________________________________

Mouth/Throat

___ Normal oral cavity and teeth
___ Abnormal (describe) ____________________________

Tonsils       present ___ enucleated ___ abnormal ___
___ Other ________________________________________
Neck/Thyroid

- Normal neck and thyroid
- Masses (describe)
- Other

Lymph Nodes

- Normal throughout (neck, axillary, inguinal, supraclavicular)
- Abnormal (describe)

Thorax/Lungs

- Normal thorax and lungs
- Abnormal (describe)

Breasts

- Normal
- Abnormal (describe)

Cardiovascular

- Normal cardiovascular system
- Cardiac murmur (describe)

- Abnormal rhythm (describe)
- Abnormal pulses (describe)
- Other

Abdomen

- Normal abdomen
- Distended
- Palpable masses (describe)

- Liver (size)
- Spleen, palpable (size)
- Abnormal bowel sounds
- Tenderness
- Other
Genital/Anal

___ Normal male or female genitalia and anus
___ Ambiguous (describe)
___ Hydrocele
___ Hernia
___ Hemorrhoids
___ Other

Musculoskeletal

___ Normal musculoskeletal system
___ Scoliosis (describe)
___ Syndactyly
___ Polydactyly
___ Abnormal hips (describe)
___ Unequal leg lengths
___ Limitation of motion (describe)
___ Abnormal gait
___ Genu Valgum
___ Other

Neurological

___ Normal cranial nerves
___ Normal reflexes (patellar, achilles, biceps)
___ Normal cerebellar signs
___ Normal muscle tone
___ Abnormalities:
Summary:

___ Normal exam
___ Abnormalities:

__________________________________________________________________________

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Physician’s Name (PRINT) ____________________________  Physician’s Signature ____________________________