

Family Physician Form

Name _____ Birth date _____ Age _____
 Address _____ Parent/Guardian _____
 _____ Physician Name & Phone # _____
 Phone _____ Grade _____

Health History (Please provide dates)

Allergies _____ Asthma _____ Rheumatic Fever _____
 Action Plan Yes _____ No _____
 Otitis Media _____ Lyme Disease _____ Neuromusc. Dis. _____
 Cong. Defects _____ Chicken Pox _____ Strep. Infect. _____
 Drug Sensitivities _____ Convulsive Dis _____ Mononucleosis _____
 Hepatitis _____ Diabetes _____ Heart Disease _____
 Other _____
 Surgeries or Injuries _____
 Comments _____

Vaccine Type	Disease Date	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	Mo/Day/Yr
Diphtheria, Tetanus, Pertussis (DPT)							
Polio (OPV) Oral Polio Vaccine							
Mumps, Measles, Rubella (MMR)							
Measles					Serology	Date:	Titer:
Rubella					Serology	Date:	Titer:
Mumps					Serology	Date:	Titer:
Haemophilus B (HIB)							
Hepatitis B							
Varicella							
Other							

Physical Assessment Date: _____
 Height _____ Weight _____ B/P _____
 Eyes _____ Throat _____ Hernia _____ Nutrition _____
 Ears _____ Teeth-Mouth _____ Genito-Urinary _____ Speech _____
 Lymph Glands _____ Heart _____ Posture _____ Nervous System _____
 Thyroid _____ Lungs _____ Feet _____
 Nose _____ Abdomen _____ Skin _____ General Appearance _____
 Biennial Scoliosis Screening
 (Beginning at Age 10) _____

Comments and/or Recommendations (include any limitations and/or RX) _____

Signature: _____