

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:

Relationship	Age	Weight	Height
Mother			
Father			
Siblings			

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: _____

V. Review of Systems

		<u>YES</u>	<u>NO</u>	<u>Comment on "YES"</u> <u>Answers</u>
General	Excessive tiredness	_____	_____	_____
	Poor sleeper	_____	_____	_____
	Other	_____	_____	_____
Head and Neck	Headaches	_____	_____	_____
	Neck pain	_____	_____	_____
	Neck swelling	_____	_____	_____
	Lumps	_____	_____	_____
	Other	_____	_____	_____
Eyes	Strabismus	_____	_____	_____
	Glasses	_____	_____	_____
	Blurring	_____	_____	_____
	Double vision	_____	_____	_____
	Pain/itch/watery	_____	_____	_____
	Other	_____	_____	_____
Ears	Hearing problems	_____	_____	_____
	Ear infections	_____	_____	_____
	Dizziness	_____	_____	_____
	Other	_____	_____	_____
Nose	Bleeds	_____	_____	_____
	Itching	_____	_____	_____
	Obstruction	_____	_____	_____
	Other	_____	_____	_____
Mouth	Teeth problems	_____	_____	_____
	Hoarseness	_____	_____	_____
	Mouth ulcers	_____	_____	_____
	Pharyngotonsillitis	_____	_____	_____
	Other	_____	_____	_____
Respiratory and Cardio-vascular	Cough	_____	_____	_____
	Short of breath	_____	_____	_____
	Chest pain	_____	_____	_____
	Palpitations	_____	_____	_____
	Other	_____	_____	_____

		<u>YES</u>	<u>NO</u>	<u>Comment on "YES"</u> <u>Answers</u>
Gastro- intestinal	Abdominal pain	_____	_____	_____
	Nausea/ vomiting	_____	_____	_____
	Constipation/ diarrhea	_____	_____	_____
	Poor appetite	_____	_____	_____
	Bleeding	_____	_____	_____
	Other	_____	_____	_____
Genito- urinary	Enuresis	_____	_____	_____
	Dysuria	_____	_____	_____
	Frequency/ urgency	_____	_____	_____
	Hematuria	_____	_____	_____
	Lump in breasts	_____	_____	_____
	Hernia	_____	_____	_____
	Other	_____	_____	_____
Musculo- skeletal	Joint pain	_____	_____	_____
	Joint swelling	_____	_____	_____
	Limps	_____	_____	_____
	Gait problems	_____	_____	_____
	Other	_____	_____	_____
Skin	Rashes	_____	_____	_____
	Lumps	_____	_____	_____
	Nevi	_____	_____	_____
	Hemangioma	_____	_____	_____
	Other	_____	_____	_____
Neuro	Muscle waisting	_____	_____	_____
	Numbness	_____	_____	_____
	Hyperactivity	_____	_____	_____
	Other	_____	_____	_____

Physical Examination

Date: _____

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

_____ Pale

_____ Cyanosis

_____ Jaundice

_____ Peeling

_____ Bruising

_____ Petechiae

_____ Cafe' au lait

_____ Hemangioma

_____ Simean crease

_____ Rash

_____ Webbing

_____ 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:

