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EPSDT completed ☐

RESOURCE FAMILY – MEDICAL EXAMINATION FORM: 23 MONTHS AND OLDER

NAME: ______________________ DOB: ______________ DATE OF EXAM: _____________

1. Does the child have a history of any of the following:
   a. Serious illness. If so, please list ____________________________________
   b. Broken bones. If so, please list ____________________________________
   c. Allergies. If so, please list ______________________________________
   d. Operations. If so, please list _____________________________________
   e. Hospitalizations. If so, please list __________________________________
2. Does the child take any medication? If so, please list

   ____
3. Last date of: TB Test: ________________ DT Booster: __________Polio: _______________

   Rubella Status: _______ Hep. B: (1) ______________ (2) _____________ (3) _____________

   Haemophilus Influenza Type B (HIB) ______________Varicella Vaccine (Chicken Pox) ____________

   Pap Smear: _______ Date/LMP: __________ Regular _____ Problems _______

   Last Sexual Experience: ___________

   Sickle Cell test results: ________ Test date: _____ Conducted by: _____________
4. Use of Street Drugs. If so, please list amount used, frequency, withdrawal symptoms:

   ____

   Use of Alcohol. If so, please list amount, frequency, withdrawal symptoms:

   ____

   Use of Cigarettes. If so, please list amount and frequency: ___________________________

   Use of Birth Control. If so, please list: _____________________________________
5. Concern Regarding: Pregnancy? Yes _____No___ Venereal Disease. If so, please explain: _______________
6. Review of systems: Temp: ________ Pulse: __________ Respiration: _______ B/P: _______

   Height: _______ Weight: _______ lbs. _______ oz. Appetite: __________

   Oriented to Person: _________ Place: __________ Time: _________Race: _________

   Characteristic Markings: ____________________Eye Color: _________ Hair Color: ____

   Hearing: __________ Audiometer results: (R) _________ (L) ________ Pass ____ Fail____

   Bruises: ________________ Lesions: ______ Rash: ____________

   Visual Acuity: Far (R) ________ (L) _______ Diagnostic only: __________________

   With/Without Glasses: Near (R) _______ (L) _______ UA _______ HCT ___________

   Has Glasses: ____________ Wears Glasses: _______________

General appearance:	NORMAL	ABNORMAL	COMMENTS
Skin	_______	_______	
HEENT	_______	_______	
Dental	_______	_______	
Neck (Thyroid)	_______	_______	
Lymph Nodes	_______	_______	
Chest (Breasts)	_______	_______	
Heart	_______	_______	
Abdomen	_______	_______	
Genitalia/Hernia	_______	_______	
Extremities	_______	_______	
Orthopedic (Spine)	_______	_______	
Neurological	_______	_______	
Mental Status	_______	_______	

GENERAL IMPRESSIONS: RECOMMENDATIONS:

Physician ____________________ Nurse ________________ Date: ___________