

# Pediatric Physical Examination

## Clinic/Hospital Information

Name:

Address:

Contact Number:

Physician/Pediatrician:

Date of Exam:

Time of Exam:

## Patient Information

Name:

Age:

Date of Birth:

Gender:

Parent/Guardian Name:

Reason for Visit:

## Medical History

Past Medical History:

Immunization Status:

Allergies (if any):

Medications:

Family Medical History:

Dietary Habits:

Physical Activity Level:

## Vital Signs

Temperature:

Heart Rate:

Respiratory Rate:

Blood Pressure:

Oxygen Saturation:

## Growth Measurements

Weight:

Height/Length:

Head Circumference (infants):

BMI (if applicable):

## Physical Examination

### 1. General Appearance

Behavior:

Nutritional Status:

Activity Level:

### 2. Skin

Inspection for Rash, Lesions, Bruises:

### 3. Head and Neck

Head Shape and Fontanelles (infants):

Eyes (Pupillary Response, Red Reflex):

Ears (Hearing, Tympanic Membrane Appearance):

Nose and Throat (Mucosa, Tonsils, Teeth):

### 4. Cardiovascular

Heart Sounds:

Pulses:

### 5. Respiratory

Breath Sounds:

Respiratory Effect:

### 6. Gastrointestinal

Abdominal Palpation:

Liver/Spleen Size:

**7. Musculoskeletal**

Range of Motion:

Muscle Tone and Strength:

**8. Neurological**

Reflexes:

Sensory and Motor Function:

**9. Genitourinary** (as indicated)

External Genitalia:

**Developmental Screening**

Milestones Achieved:

Areas of Concern:

**Immunizations and Preventive Care**

Administered Today:

Scheduled Next:

**Assessment and Plan**

Findings:

Diagnosis:

Treatment Recommendations:

Follow-Up Instructions:

**Physician's Signature**

Date:

**Parent/Guardian Acknowledgment**

I, \_\_\_\_\_, acknowledge the findings and recommendations from today's physical exam.

Signature:

Date: