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: