



Cardinal Cushing Centers

ANNUAL PHYSICAL EXAMINATION

NAME _____ DATE OF EXAM _____ DOB _____
HEIGHT _____ WEIGHT _____ TEMP _____ PULSE _____ BP _____

IMMUNIZATIONS COMPLETED AT TIME OF THIS PHYSICAL

(Series of Dates)DPT Series _____ TD _____

Polios _____ MMR#1 _____ #2 _____

Flu _____ Hepatitis B#1 _____ #2 _____ #3 _____ TB _____

HEAD:Scalp _____ Hair _____ Ears _____ Eyes _____ Mouth _____ Nose _____

Throat _____ Teeth _____ Neck _____ Tonsils _____

VISION:

ABDOMEN:Contour _____ Tenderness _____ Masses _____

Hernias _____

CHEST: _____ HEART: _____ LUNGS: _____

BONES, JOINTS, MUSCLES, SKIN:Scoliosis Screen _____ Redness, tenderness,

swelling _____ Scars, abrasions, sores, deformities _____ Limitation of motion,

coordinations: _____

NEUROLOGICAL:

RECTUM AND GENITALIA:

Hemorrhoids, fistula _____

Normal development _____

Menstruation, regular, pain, discharge _____

TESTS: COPIES OF ALL LAB REPORTS ARE REQUIRED

Serology/Urinalysis _____ Tuberculin _____

Cervical Spine X-Ray(Downs Syndrome Only) _____

Atlantoaxial Dislocation: Positive _____ Negative _____

Other _____

ALLERGIES:

PRESENT MEDICATIONS:

DIAGNOSIS:

CURRENT MEDICAL PROBLEMS:

THIS PATIENT MAY /MAY NOT PARTICIPATE IN ALL ACTIVITIES AND COMPETITIVE SPORTS

SIGNATURE AND ADDRESS OF PHYSICIAN: _____

DATE: _____