Children's Services of Virginia, Inc.

Annual Physical Examination Verification

Date of Exam _____

Patient's Name _____ Date of Birth _____

Health Assessment: Weight: _____ Height: _____ Blood Pressure _____

Physical Examination (please check the appropriate box)

	Within Normal Limits	Abnormal/ Recommended Follow Up		Within Normal Limits	Abnormal/Recommended Follow Up
HEENT			Neurological		
Lungs			Nutritional Status		
Heart			Extremities		
Skin			Urinary		
Genital			Psych/Mental		
Abdomen					

Needed Follow Up: _____

Medical and Developmental History

Assessment For:	Within Normal Limits	Concern Identified	Referred for Evaluation
Emotional/Social			
Problem Solving			
Communication			
Fine Motor Skills			
Gross Motor Skills			

Does the child have any food and/or medication allergies? ___ YES ___ NO

If yes, please explain: _____

Does the child have any chronic conditions, developmental delays or disabilities? ___ YES ___ NO

If yes, please explain: _____

Does the child have any special dietary/nutritional needs or other concerns? ___ YES ___ NO

If yes, please explain: _____

Vision/ Hearing Screen: (please complete each screening or check appropriate box)

Vision:

Uncorrected: R20/_____ L20/_____

Corrected : R20/_____ L20/_____

- ☐ Not Tested - No vision concerns
- ☐ Referred to eye doctor
- ☐ No Referral – Already receiving care

Hearing:

- ☐ Not Tested – No hearing concerns
- ☐ Referred to Audiologist/ENT
- ☐ Hearing Impaired – Already receiving services

TESTED: (results below)

Right Ear: _____

Left Ear: _____

Communicable Disease Risk Assessment

1. Does patient have signs/symptoms of a communicable disease/TB disease? _____ YES _____N0
2. Is patient a member of a high risk group? _____ YES _____NO

- IF NO to both questions above, no further evaluation is needed.
- **IF YES** to either question, patient must undergo further testing.
- The type of test administered: _____
- Results: _____

Health Care Provider's Information (please print clearly, signature needed for validation of form)

Name (print) _____ Signature: _____ Date:_____

Office Name: _____ Address:_____

Phone Number: _____ Fax Number: _____