



TWIN PINES FAMILY SERVICES, LLC

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PHYSICAL EXAMINATION FORM

☐ FOSTER CARE INTAKE ☐ WELLNESS (EPSDT) ☐ SICK VISIT

EXAMINATION DATE: _____

☐ ORIGINAL APPOINTMENT

☐ RESCHEDULED APPOINTMENT: ☐ BY OFFICE ☐ BY FOSTER PARENT

PATIENT'S NAME: _____ DATE OF BIRTH: _____

GENDER: ☐ MALE ☐ FEMALE RACE: _____ HEIGHT: _____ WEIGHT: _____

BLOOD PRESSURE: _____ PULSE: _____ RESPIRATIONS: _____

PLEASE INDICATE: 1 – NORMAL 2 – ABNORMAL

_____ EYES	_____ TEETH	_____ HEART	_____ BREASTS
_____ EARS	_____ NECK	_____ MURMURS	_____ GENITALS
_____ NOSE	_____ SPINE	_____ ABDOMEN	_____ EXTREMITIES
_____ THROAT	_____ LUNGS	_____ SKIN	_____ PHYSICAL GROWTH

RECOMMENDATIONS AND/OR COMMENTS:

MEDICATION(S) PRESCRIBED: _____ (ATTACH UTD RECORD)

IMMUNIZATIONS RECEIVED: ☐ NO ☐ YES (ATTACH UTD RECORD)

☐ FOLLOW-UP NEEDED: SCHEDULED FOR:

DAY: MON TUES WEDNES THURS FRI SAT SUN DATE: _____

☐ NEXT WELLNESS EXAM: SCHEDULED FOR:

DAY: MON TUES WEDNES THURS FRI SAT SUN DATE: _____

PHYSICIAN'S SIGNATURE

DATE

NAME OF OFFICE/ADDRESS/PHONE NUMBER