Iowa Department of Human Services

Physical Record

Child's Name	Sex	Place of Birth	Date of Birth

FAMILY DISEASES (Check only those applicable)

- ❑ Heart problems
- ❑ Venereal
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Epilepsy
- ❑ Alcoholic
- ❑ Diabetes
- ❑ Cancer

Other diseases _____

PREVIOUS DISEASES OF THIS CHILD (Check only those applicable and list approximate dates for previous disease.)
STATE SOURCE OF ABOVE INFORMATION – ATTACH RECORD OF IMMUNIZATIONS AND BOOSTERS.

- ❑ Chickenpox _____
- ❑ Influenza _____
- ❑ Measles _____
- ❑ Mumps _____
- ❑ Scarlet fever _____
- ❑ Arthritis _____
- ❑ Injuries _____
- ❑ Whooping cough _____
- ❑ Tonsillitis _____
- ❑ Operations _____
- ❑ Meningitis _____
- ❑ Rheumatic fever _____
- ❑ Pneumonia _____
- ❑ Tuberculosis _____
- ❑ Sexually transmitted disease _____
- ❑ Seizures _____
- ❑ Other _____

CHRONIC ILLNESS OF THIS CHILD (List of medications prescribed to treat chronic conditions)

Bedwetting (after 8 years old)
Chronic ear problem
Allergies
Malnutrition
Constipation
Other chronic illnesses

PHYSICAL EXAMINATION (Please write recommendation on other side)

Date	B/P	Pulse	Nasal passages
Height		Weight	Teeth
Normal height	A-C	Under W	Tonsils
General development			Glands
Posture defects			Heart
Orthopedic defects			Lungs
Hemoglobin or hematocrit			Skin and scalp
Eyes			Abdomen
Vision-Snellen test R-20		L-20	Genitalia
Ears – (drums)			Neurological
Hearing test – Rt		L	Remarks

Test	For Diagnosis	Date Taken	Result
Sickle cell			
Serology			
Lead poisoning			
Wasserman			
Vaginal smear			

Tuberculin test _____

Urinalysis _____ Specific gravity _____ Albumen _____ Sugar _____ Microscopic _____

Initial examination by doctor _____ Date completed _____

PRELIMINARY DIAGNOSIS AND RECOMMENDATIONS

Signed doctor _____ Date _____

CORRECTIVE WORK DONE

Date	Diagnosis	Treatment Given	By Whom

MENTAL HEALTH

Do you have concerns about the child's mental health needs related to emotions, behaviors, developmental, education, substance abuse, or family situation? ❑ No ❑ Yes

Do you recommend further assessment or evaluation? ❑ No ❑ Yes

What do you recommend to be further evaluated? _____

DENTAL HEALTH

Do you have concerns about the child's dental health? ❑ No ❑ Yes

Do you recommend further assessment or evaluation? ❑ No ❑ Yes

What do you recommend to be further evaluated? _____

Physician Name		Telephone ( )	
Street	City	State	Zip Code