EARLY EXPLORERS
Head Start & Early Head Start

Physical Exam Record

Child's Name					
Date of Birth	**Age at time of Visit**	**Sex** □ M □ F	**Height**	**Weight**	**Head Circumference**

I feel it is necessary to do a hemoglobin/ urine/lead test on the above-named child. □ Yes □ No	**Hemoglobin**	**Urinalysis**	**BMI**
Current illness/disease	**Respirations**	**Pulse**	**Blood Pressure**

Eyes/Vision □ Normal □ Abnormal □ Refer	**Ears/Hearing** □ Normal □ Abnormal □ Refer
Head □ Normal □ Abnormal □ Refer	**Neck** □ Normal □ Abnormal □ Refer
Nose □ Normal □ Abnormal □ Refer	**Throat** □ Normal □ Abnormal □ Refer
Mouth/Dental □ Normal □ Abnormal □ Refer	**Heart** □ Normal □ Abnormal □ Refer
Lungs □ Normal □ Abnormal □ Refer	**Abdomen** □ Normal □ Abnormal □ Refer
Genitalia □ Normal □ Abnormal □ Refer	**Spine** □ Normal □ Abnormal □ Refer
Limbs □ Normal □ Abnormal □ Refer	**Neuro** □ Normal □ Abnormal □ Refer
Skin □ Normal □ Abnormal □ Refer	**Immunizations**
Referrals/Follow Up Needed	**Comments**

Provider Signature	**Date**
Practice Name	**Phone**

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