University Pediatrics

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Name of Child:_____ Birthdate: _____

Name of Parent or Guardian: _____

Address of Parent of Guardian: _____

A. Medical History *(To be completed by Parent)*

1. Is your child allergic to anything? No___ Yes___ If yes, what? _____
_____
2. Is your child currently under a doctor's care? No___ Yes___ If yes, for what reason? _____
_____
3. Is your child on any continuous medication? No___ Yes___ If yes, what? _____
_____
4. Any previous hospitalizations or operations? No___ Yes___ If yes, when and for what? _____
_____
5. Any history of significant previous diseases or recurrent illness? No___ Yes___
   Diabetes No___Yes___ Convulsions No___ Yes___ Heart Trouble No___ Yes___ Asthma No___ Yes___
   If others, what/when? _____
6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe: _____
_____
   Any mental disabilities? No___ Yes___ If yes, please describe: _____

Signature of Parent or Guardian_____**Date**_____

B. Physical Examination ~ *to be completed by your Healthcare Provider*

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (Or a comparable board from bordering states), a certified nurse practitioner.

Height _____ Weight _____ BP _____/_____ (if age appropriate)

	Normal	Abnormal	If abnormal, please explain
Head			
Eyes			
Ears			
Nose			
Teeth			
Throat			
Neck			
Heart			
Chest			
Abd/GU			
Ext			
Neurological			
Skin			
Vision			
Hearing			

Developmental Evaluation: Delayed _____Age Appropriate_____ If delay, note significance and special care needed:
_____

Results of Tuberculin Test, if given: Type _____ Date_____ Normal ___Abnormal _____

Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations: _____
_____

Date of Examination_____

Signature of authorized examiner/title_____**Phone #**_____

Immunization Record: See Attached Sheet