PEDIATRIC ASSOCIATES
OF HAMPTON & PORTSMOUTH P.C.

55 High Street • Hampton, NH • **(603) 929-3838**
330 Borthwick Avenue, Suite 202 • Portsmouth, NH • **(603) 436-7171**
www.PediatricAssociatesNH.com

Name of Child _____ Date of Birth _____

Address _____ City _____ State _____

HEALTH HISTORY

Significant Past Medical History _____

_____

Significant Family/Social History _____

_____

_____

SCREENINGS

Vision: R_____/_____ L_____/_____ Corrected : Y/N Hearing: R _____ L _____

Lead: _____ Hgb/Hct: _____ U/A: _____ Other: _____

IMMUNIZATIONS: Please see attached copy.

PHYSICAL EXAM

Date of Exam: _____ Age: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

PPD-Date: _____ Result: _____ Allergies: _____

	NORMAL	**ABNORMAL**
Eyes		
Ears, Nose, Throat		
Mouth, Teeth		
Neck, Glands		
Cardiovascular		
Chest, Lungs		
Abdomen		
Skin		
Genitalia, Hernia (Male)		
Musculoskeletal: ROM, Strength		
Spine		
Upper Extremities		
Lower Extremities		
Neuromuscular		

Tanner Stage 1 2 3 4 5

Comments: _____

Sports Participation Recommendations: _____

Name of Provider: _____ **Signature:** _____ **Date:** _____

We recommend that parents make a copy of this form for their records. A fee maybe charged for additional copies. Thank you.