Collins-Maxwell Physical Form

Name:_____ DOB:_____

Parent/Guardian:_____ Phone:_____

Date of Exam:_____

Physical Examination N=normal/negative		
Appearance	Ears	Hernia
Posture	Nose	Back
Nutrition	Mouth/Throat	Extremities
Development	Lymph Nodes	Blood Pressure
Neurological	Thyroid	UA
Speech	Heart	Hemoglobin
Skin	Lungs	Lead
Hair/Scalp	Abdomen	Height
Eyes/Vision	Genitalia	Weight

Allergies:_____

_____

Medications:_____

_____

Chronic Diseases:_____

_____

Physician Comments:_____

_____

Physician Signature:_____ Date:_____