Exceptional Families Exceptional Service

EFMP PHYSICAL EXAM FOR OVERSEAS SCREENING

Patient Name: _____ **DOB:** _____

Age: _____ **HT:** _____ **WT:**_____ **BP:** _____ **Pulse:** _____ **Temp:** _____

❖ **ONE PER FAMILY MEMBER (MAKE COPIES FOR ADDITIONAL FAMILY MEMBERS)**

Past Medical History: (Please circle any that apply)

1. Hospitalization/ER
2. Surgery
3. Chronic Pain
4. Vision
5. Dental
6. ADD/ADHD
7. Hearing
8. Asthma
9. Allergies
10. Headaches
11. OB/GYN
12. Cancer
13. Epilepsy
14. High Risk Newborn
15. Adaptive Equipment
16. Developmental Delays
17. Special Education
18. PDD/ Autism
19. Sickle Cell Disease
20. Specialty Care
21. Diabetes
22. Behavioral Health
    - Depression
    - Bi-Polar
    - Anxiety
    - PTSD
    - Other

PHYSICAL EXAM	IMPRESSION
1. GENERAL BUILD	
2. HEENT	
3. NECK	
4. LUNGS	
5. HEART	
6. CHEST	
7. LIVER	
8. SPLEEN	
9. SPINE	
10. NEURO	
11. GENITALIA	
12. SKIN	
13. EXTREMITIES	
14. DEVELOPMENTAL SCREENING (ASQ- 72 months and younger)	

_____ _____

Physician Signature/ Date Physician Stamp