FAMILY & CHILDREN SERVICES A SOURCE OF HOPE

CHILD'S ILLNESS REPORT

Patient Name:_____

Date of exam:_____

1. Physical examination

Weight_____Height_____ Head circumference_____
Temp_____Heart_____ Chest circumference_____
Eyes, nose, mouth_____ Lungs_____ Abdomen_____
Genitals_____ Extremities_____ Reflexes_____
Skin_____

2. Condition: Normal_____ Abnormal_____

Diagnosis:

Recommendations:
(treatment, prescription, dietary changes, care)

3. Immunizations given on this date:

4. Comments on general appearance, motor or intellectual development:

_____
Signature of attending physician Date