



Physician Questionnaire

(This form must be completed and signed by your Physician)

Name: Last First Birth date:

Address: Street City Zip Code

EXAMINATION

Height: Weight: Eyes: Vision: Ears: Hearing Test: Referred to ear or eye specialist? Nose: Throat: Mouth: Teeth: Is dental work indicated? Posture: General Condition: Skin: Orthopedic: Neck: Nervous System: Heart: Lungs: Abdomen: Hernia: Genitalia: Urinalysis: Allergies: Remarks / Recommendations:

IMMUNIZATIONS (Please include month/day/year)

DTP: 1st 2nd 3rd 4th DTP /DTaP4: DTP/DTaP5: Booster: Td: - Or - Tdap: Polio Vaccine (OPV/IPV): 1st 2nd 3rd 4th MMR-1: MMR-2: Hib (Hoemophilus B): 1st 2nd 3rd 4th Hepatitis B: 1st 2nd 3rd Varicella Vaccine: 1st 2nd Tuberculin Test: Date: Results:

Physician Signature

Date of Exam