

# PHYSICAL EXAMINATION

(To be completed by physician's office)

Patient's Full Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_

Please comment if abnormal: \_\_\_\_\_

SKIN \_\_\_\_\_

MOUTH/DENTAL \_\_\_\_\_

EYES \_\_\_\_\_

LYMPHATICS \_\_\_\_\_

CHEST/HEART \_\_\_\_\_

RHYTHM \_\_\_\_\_

MURMURS \_\_\_\_\_

LUNGS \_\_\_\_\_

ABDOMEN \_\_\_\_\_

GENTALLA-HERNIA \_\_\_\_\_

ORTHOPEDIC \_\_\_\_\_

NECK, BACK, SPINE \_\_\_\_\_

SHOULDERS \_\_\_\_\_

ARM, ELBOW, WRIST \_\_\_\_\_

HIP \_\_\_\_\_

KNEE \_\_\_\_\_

ANKLE \_\_\_\_\_

TARGET JOINT \_\_\_\_\_

How many bleeds/month does child average? \_\_\_\_\_

Is child on prophylaxis or immune tolerance? \_\_\_\_\_

Product \_\_\_\_\_ Dose \_\_\_\_\_

Does child self-infuse? \_\_\_\_\_ Does child have a port or PICC? \_\_\_\_\_

If yes, heparin volume \_\_\_\_\_

## RECOMMENDATIONS:

Full participation \_\_\_ Further evaluation \_\_\_ limited participation \_\_\_ no participation \_\_\_

Comments: \_\_\_\_\_

I certify that I am qualified to perform this examination:

Physician Signature

Date