Valley Hill
Youth Treatment Centre

Physical Examination

Name: _____
PHN: _____
DOB: _____

Vital Signs: BP_____ HR_____ RESP_____HT_____WT_____ TEMP_____

	Normal	Abnormal	Not assessed	Specify abnormalities
Skin				
Head				
Eyes-general				
Eyes-funduscopic				
Ear & Nose				
Mouth				
Neck				
Cardiovascular				
Respiratory*(thorax)				
Abdomen				
Lymph nodes				
Extremities				
CNS-Gait				
Level of Consciousness				
Cranial Nerves				
Neuro-Reflex				
Motor& Sensory				
Breasts/genital/rectal				

Medications (include OTC drugs) _____

Allergy (also describe reaction)_____

Past Medical History_____

Head Lice (Please check) Yes ___ No ___ when was Head Lice treatment completed? _____

CBC
Lytes/BUN/CR
F.B.S Spot Okay
Liver Function test
HBSAG/B/C
Routine Urinalysis

Diagnoses and Proposed Management
_____
_____

Physician's Signature _____ Date_____