LRCC
Little Rock Children's Clinic
27 Corporate Hill Dr. Suite 100
Little Rock, AR 72205
501-227-6727

Health Assessment

Child's Name:_____ Birth Date:_____ Sex:_____ Race:_____
Parent's Name:_____

Required				Laboratory (as indicated)			
	NL	ABNL	Comments		Date	NL	Comments
BP: WT: HT:				Hemoglobin			
Skin: Color, rash, swelling, hair, nails				Hematocrit			
Eyes: Conjunctiva, Cornea, Pupils, Extraocular Movement				Urinalysis			
Ears: Pinnae, Canals: Tympanic Membrane Appearance, Mobility				Other			
Nose: Nares, Turbinates							
Mouth: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx				Medications:_____			
Neck: Thyroid, Range of Motion							
Nodes: Cervical, Axillary, Inguinal, Other				Diet Restrictions:			
Heart: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses							
Lungs: Rate, Auscultation, Percussion				Special Equipment:			
Abdomen: Contour, Palpation of Liver, Spleen, Kidney, Mass, Tenderness							
Genito-Urinary: Female External, Male Penis, Meatus, Testes, Hernia				Allergies:			
Musculoskeletal: Range of Motion, Tenderness, Edema, Clubbing, Spine (curvature)							
Neurological: Gait, Cerebella Function, Motor, System (strength, tone); Cranial Nerves (Gross)				General Comments or Recommendations:			
Developmental							
Gross Motor							
Fine Motor							
Social							
Speech/Language							

_____I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

_____This child's shots are up to date.

Signature of Physician, Nurse, or School Professional:_____

Phone_____ Date:_____