PHYSICAL EXAMINATION FORM

EXCEPTIONAL FAMILY MEMBER PROGRAM, WOMACK ARMY MEDICAL CENTER
2817 Reilly Road, Bldg 2817, Fort Bragg NC 28310-7301
Ph. (910) 907-3367 / Fax (910) 907-8752

Patient Name (Last, First, Middle)_____ Date of Birth _____

❑ Male ❑ Female Age _____

Part I —Please answer these health history questions *before* the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

1. Allergy requiring shots and/ or life-threatening	**Y N**	**9. Hospitalization or Emergency Room visit in past 5 years (other than childbirth)**	**Y N**
2. Developmental Delays	**Y N**	**10. Heart problems**	**Y N**
3. Asthma	**Y N**	**11. Bleeding disorders**	**Y N**
4. Vision disorders/ blindness	**Y N**	**12. Counseling or Medications for a mental health condition in past 5 years**	**Y N**
5. Seizures	**Y N**	**13. Seizure treatment**	**Y N**
6. Problems hearing/ deafness	**Y N**	**14. Diabetes**	**Y N**
7. Problems with speech	**Y N**	**15. ADHD/ ADD**	**Y N**
8. Please list any medications:		**16. Autism/ PDD/ Aspergers**	**Y N**
		17. Special Education Considerations (IEP, IFSP, 504 Plan)	**Y N**
		18. Cancer	**Y N**
		19. Immunizations up to date	**Y N**
		20. Abnormal Pap/ GYN history	**Y N**
		21. Ongoing health Concerns/ Chronic illness	**Y N**

Please explain all "yes" answers here. Include the year and age at the time and duration of treatment/ongoing.

_____

_____

_____

_____ *continue on back*

PART II: Below to be completed by a medical health professional.

DD Form 2792 Completed?* Y N

any medical, psychological or educational condition that currently REQUIRES specialist care (to include internal medicine, pediatrics, neuro, pulmonology, psych, PT, OT, etc) *requires completion of DD Form 2792 by the specialist or primary care provider following patient

Vitals: B/P _____ Pulse _____ RR _____ Temp _____ Ht _____ Wt _____

Physical Exam: Impression/Notes:

GENERAL:

HEENT:

RESP:

GI:

GU:

MS:

OB/GYN/PAP (if applicable)

Summary/Plan: _____

Date: _____

Medical Providers Signature: _____Credentials/Name/Stamp: _____

Name of Facility: _____ Contact Number: _____