DPP-106C
(R. 8/07)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services

☐ **Initial Physical**
☐ **Annual Physical**

CHILD MEDICAL HISTORY AND ANNUAL PHYSICAL EXAM

Child Name (First, Middle, Last) | Date of Birth | DATE

Gender | Twist Individual ID number

Case Name

SECTION I: THIS SECTION TO BE COMPLETED BY PARENT/DCBS STAFF AND/OR FOSTER PARENT
Information from 106A should be incorporated if applicable

REVIEW OF SYSTEMS/CONDITIONS: (CHECK APPLICABLE – If checked describe in *Comments*)

SKIN: ☐ **No Difficulties** ☐ Infectious Condition ☐ Eczema/Dry Skin ☐ Bruising
☐ Warts/lesions ☐ Burns ☐ Hair/Nail Problems ☐ Scars/tattoos
Comments:

NEUROLOGICAL:
☐ **No Difficulties** ☐ Seizures ☐ Head Injury ☐ Cerebral Palsy
☐ Movement Disorder ☐ Frequent/Recurrent Headache ☐ Dizziness ☐ Other Neurological
Comments;

VISUAL (EYES AND VISION):
☐ **No Difficulties** ☐ Blindness ☐ Eyeglasses ☐ Other Visual
Comments:

AUDITORY (EARS AND HEARING):
☐ **No Difficulties** ☐ Hearing Loss ☐ Ear Tubes ☐ Other Auditory
Comments:

MOUTH, NOSE AND SINUSES:
☐ **No Difficulties** ☐ Runny nose ☐ Nosebleeds ☐ Sinus Infections
☐ Tonsillectomy/Adenoidectomy ☐ Recurrent Sore throat ☐ Hoarseness ☐ Dental
Comments:

RESPIRATORY (BREATHING AND LUNGS):
☐ **No Difficulties** ☐ Smoking ☐ Chronic Cough ☐ Pneumonia
☐ History of TB or + Skin test ☐ Asthma ☐ Frequent Colds ☐ Other
Comments:

CARDIOVASCULAR (HEART, ARTERIES AND VEINS):
☐ **No Difficulties** ☐ Heart Murmur ☐ Heart Surgery ☐ Arrhythmia
☐ High Blood Pressure ☐ Shortness of Breath ☐ Other Cardiovascular
Comments:

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NUTRITIONAL (FOOD AND DIET)

☐ Overweight ☐ Underweight ☐ Food Intolerance ☐ Other

Comments:

GASTROINTESTINAL (STOMACH AND DIGESTION):

☐ **No Difficulties** ☐ Constipation ☐ Diarrhea ☐ Vomiting
☐ Food Intolerance ☐ Encopresis (soiling) ☐ Ulcer ☐ Other GI

Comments:

URINARY (KIDNEYS AND URINE):

☐ **No Difficulties** ☐ Bed/Day-wetting ☐ Infections ☐ Other GU

Comments:

ENDOCRINE (GLANDS AND HORMONES):

☐ **No Difficulties** ☐ Diabetes ☐ Growth Problems ☐ Other Endocrine

Comments:

MUSCULOSKELETAL (MUSCLES AND BONES):

☐ **No Difficulties** ☐ Joint Pains/Swelling ☐ Scoliosis ☐ Back Pain
☐ Congenital Deformities ☐ Amputations ☐ Broken Bones ☐ Other

Comments:

GENITAL/REPRODUCTIVE:

☐ Sexually Transmitted Disease ☐ Sexual Abuse Victim ☐ Other GU
Male: ☐ Penile Discharge ☐ Testicular Pain/Swelling
Female: ☐ Vaginal Discharge ☐ Menstrual Difficulties ☐ Pregnancies ☐Breast Lump

Comments:

HEMATOLOGICAL (BLOOD):

☐ **No Difficulties** ☐ Anemia ☐ Bleeding ☐ Leukemia

Comments:

MENTAL HEALTH/SUBSTANCE ABUSE:

☐ **No Difficulties** ☐ Depressed Mood ☐ Bipolar Disorder ☐ Anxiety/Panic
☐ Obsessive/Compulsive ☐ Attention Deficit Hyperactivity ☐ Eating Disorder ☐ Learning Disorder
☐ Autism ☐ Mental Retardation ☐ Out of Control Behavior
☐ Alcohol Abuse ☐ Marijuana Abuse ☐ Other Drug Abuse ☐ Other Mental Health

Comments:

BIRTH HISTORY:

In what city and state was the child born? (Describe)_____
In what hospital was the child born? (Describe) _____
Did this child have any prenatal complications? (Describe) _____
At what gestational age was this child born? (Describe) _____Birth Weight _____
Did this child have any complications of birth? (Describe)_____
Was this child exposed to tobacco, alcohol or other drugs during pregnancy? (Describe)_____

BLOOD TYPE:

☐***O+*** ☐***A+*** ☐***B+*** ☐***AB*** ☐***O−*** ☐***A−*** ☐***B−*** ☐***AB−***

DEVELOPMENTAL HISTORY:

Did/Does this child have any delays in reaching motor milestones such as sitting or walking? (Describe)_____

_____

Did/Does this child have any delays in learning to talk at appropriate ages? (Describe)_____
_____

CURRENT MEDICATION:

Medication	Dose	Reason	Prescribed by

DOES THIS CHILD HAVE ANY DRUG ALLERGIES? (LIST)_____
DOES THIS CHILD HAVE ANY FOOD ALLERGIES(LIST)_____
DOES THIS CHILD HAVE ANY ENVIRONMENTAL ALLERGIES (POISON IVY, Bee Stings, etc)?_____

HOSPITILIZATIONS:

Date:	Hospital, Location	Reason	Doctor(S)

CURRENT MEDICAL PROVIDERS: (Include Mental health care providers)

Doctor, Location	Specialty (i.e. cardiology, ENT,)	Condition Treated	Last Seen

DOES THIS CHILD HAVE ANY NEED FOR SPECIALIZED MEDICAL EQUIPMENT? (DESCRIBE):

_____
_____
_____
_____
_____

_____ **Completed by:** ☐**Parent**
Signature **Date** ☐**Foster Parent/Caretaker** ☐**Social Worker**

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SECTION II: THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER

EXAM **Ht:** **Wt:** **Temp** **B/P** **Pulse**

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS/FINDINGS
General				
HEENT				
Neck				
Lungs				
Heart				
Abdomen				
Genitalia				
Nodes				
Extremities				
Neuro				
Skin				
Other				

DEVELOPMENTAL

GROSS MOTOR:

FINE MOTOR:

LANGUAGE:

PERSONAL SOCIAL:

Hearing

	Right	Left
1000		
2000		
3000		

Vision

Right	
Left	
Both	

Based on your observations, do you think this child needs referrals for other medical or psychiatric/therapeutic services? ☐ Yes ☐ No If Yes, please describe: _____
_____
_____

Based on your observations, do you think this child has any specialized needs due to any drug exposure?
☐ Yes ☐No If Yes, please describe: _____
_____
_____

Findings: _____
_____

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Recommendations:_____

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_____, _____ _____

Physician or Health Care Professional's Signature **Title** **Date**

_____

Address **Telephone Number**