COTSWOLD PEDIATRICS

3030 Randolph Rd, Suite 102 Charlotte, NC 28211
Phone: 704-512-4475, Fax: 704-512-4478

Name of Child:_____ Birthdate: _____

Name of Parent or Guardian: _____

Address of Parent of Guardian: _____

A. Medical History *(To be completed by Parent)*

1. Is your child allergic to anything? No___ Yes___
If yes, what? _____

2. Is your child currently under a doctor's care? No___ Yes___
If yes, for what reason?_____

3. Is your child on any continuous medication? No___ Yes___
If yes, what? _____

4. Any previous hospitalizations or operations? No___ Yes___
If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___
Diabetes No___Yes___ Convulsions No___ Yes___ Heart Trouble No___ Yes___
Asthma No___ Yes___
If others, what/when? _____

6. Does the child have any physical disabilities: No___ Yes___
If yes, please describe:
_____

Any mental disabilities? No___ Yes___
If yes, please describe:
_____

Signature of Parent or Guardian_____**Date**_____

B. Physical Examination (*To be completed by your Healthcare Provider)*

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), or a certified nurse practitioner.

Height _____ Weight _____ BP _____/_____ (if age appropriate)

	Normal	Abnormal	If abnormal, please explain
Head			
Eyes			
Ears			
Nose			
Teeth			

Throat			
Neck			
Heart			
Chest			
Abd/GU			
Ext			
Neurological			
Skin			
Vision			
Hearing			

Developmental Evaluation: Delayed _____Age Appropriate_____
If delay, note significance and special care needed:

_____

_____

Results of Tuberculin Test, if given: Type _____ Date_____ Normal ___Abnormal _____

Should activities be limited? No___ Yes___ If yes, explain:_____
Any other recommendations:

_____

_____

Date of Examination_____

Signature of authorized examiner/title_____

Phone _____

Immunization Record: See Attached Sheet