GCCARD EARLY HEAD START PHYSICAL EXAMINATION/ASSESSMENT FOR A PREGNANT FEMALE

The following information is requested so that we can work together to meet your physical, intellectual, and emotional needs. Fill out the information on the front page; the information on the back is to be completed by a doctor, nurse or physician assistant. This information is strictly confidential.

PERSONAL INFORMATION

NAME: ________________B.D._________PHONE:_________

ADDRESS: ______________CITY:_____________ZIP:_____

MEDICAL HISTORY **What is your due date?_____________**

Is this your first pregnancy? ❑ No ❑ Yes Comment______________

Do you have dental problems or sore mouth, teeth or gums? ❑No ❑Yes _____

Do you have or been told you have any of the following:

HEALTH CONDITION	NO	YES	EXPLAIN (YES RESPONSES)
High Blood Pressure			
Diabetes			
Heart Disease/Trouble			
Asthma			
Immune Problem			
Food Allergy			
Other Allergies			

When did you start prenatal care?____

Other High Risk Factors:____

Do you take any medications regularly? ❑No ❑Yes ❑ Prescription ❑Vitamins

If yes, what medication(s):____

Reason for medication(s): ____

I certify that this health history is true, to the best of my knowledge:

____

SIGNATURE DATE

I give permission for this information to be shared between GCCARD Early Head Start and my Health Care Provider:____

SIGNATURE DATE

PHYSICAL EXAMINATION, INSPECTION, TEST, AND MEASUREMENTS (To be completed by Physician)

EXAMINATION/TEST	RESULTS	NORMAL	UNDER CARE
Vision Exam? ❑ Left Eye ❑ Right Eye			
Hemoglobin/Hematocrit?			
Urinalysis?			
Blood Pressure?			
Height?			
Weight?			

ESSENTIAL FINDINGS DEVIATING FROM NORMAL AND/OR RECOMMENDATIONS

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COMMENTS

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EXAMINER'S SIGNATURE   DATE   EXAMINER'S NAME (PRINT OR TYPE)   DEGREE/LICENSE

____

NUMBER & STREET   CITY   ZIP   PHONE

AMT/CM
EHSPHS.DOC 2/2011

REVIEWED BY ______________________________
INITIALS (STAFF ONLY)