

PEDS-C

Vital Signs and Symptom Directed Physical Exam

PDC 11
Rev 0
12/22/2004
Page 1 of 3

Please Use Black Pen To Fill Out Form.

24921

Week # <i>week</i>	Date of Assessment <i>assessdf</i>	Patient ID <i>idn</i>	Patient Letter Code <i>letcode</i>	<i>corrfix</i> Correction
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	
	<small>mm dd yyyy</small>			

Instructions

Use this form to record vital signs and physical exam results when indicated.

Vital Signs and Physical Measurements

1. Weight: <input type="text"/> <i>vswt</i> <input type="text"/> kg	2. Height: <input type="text"/> <i>vsht</i> <input type="text"/> cm
3.A. Temperature: <input type="text"/> <i>vstmp</i> <input type="text"/> C	3.B. Site: Oral <input type="radio"/> <i>vstmpsit</i> Tympanic <input type="radio"/> Axillary <input type="radio"/> Not possible to measure <input type="radio"/> <i>vstmpna</i>
4. Blood Pressure: A. Systolic <input type="text"/> <i>vssysbp</i> mmHg	B. Diastolic <input type="text"/> <i>vsdiabp</i> mmHg
5. Pulse: <input type="text"/> <i>vspuls</i> bpm	Unable to obtain <input type="radio"/> <i>vspulsna</i>

CRA Use Only

Physical Exam

6. Was a symptom directed physical exam indicated at this visit? Yes No *vsexmind*

If **No**, skip to item 9.

If **Yes**, indicate if the listed body area or organ system is within normal limits. Specify or comment if the response is **No**.

7. Body areas	1. Yes No	2. Specify / Comment
A. Head, eyes, ears:	<input type="radio"/> <input type="radio"/>	<i>vshead</i>
B. Nose, mouth, throat:	<input type="radio"/> <input type="radio"/>	<i>vsnose</i>
C. Neck:	<input type="radio"/> <input type="radio"/>	<i>vsneck</i>
D. Chest (including breasts, axillae):	<input type="radio"/> <input type="radio"/>	<i>vschst</i>
E. Genitalia, groin, buttocks:	<input type="radio"/> <input type="radio"/>	<i>vsgntl</i>
F. Abdomen:	<input type="radio"/> <input type="radio"/>	<i>vsabdm</i>
G. Each extremity:	<input type="radio"/> <input type="radio"/>	<i>vsextm</i>
H. Back, including spine:	<input type="radio"/> <input type="radio"/>	<i>vsback</i>
I. Skin:	<input type="radio"/> <input type="radio"/>	<i>vsskin</i>

Signature: _____

Certif. #: _____

staffid1 -

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29682

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week

Date of Assessment
assessdf
mm / dd / yyyy

Patient ID
idn

Patient Letter Code
letcode

corrfix
Correction

Physical Exam (Continued)

CRA Use Only

8. Organ systems

1. Yes No 2. Specify

A. Neurologic: *vsneur*

B. Psychologic: *vspsyc*

C. Genitourinary: *vsgnto*

D. Hematologic / Lymphatic: *vshmt0*

E. Allergies / Immunologic: *vsallr*

F. Musculoskeletal: *vsmusc*

G. Other: *vs0throg*

Referral

9.A. Was the patient referred to another health professional? Yes No *vsrefr*

B. Reason for referral: _____

C. Date of referral: / / *vsrefrdt*
mm dd yyyy

D. Name of health professional: _____

Signature: _____

Certif. #: *staffid2* -

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37238

Week # <i>week</i>	Date of Assessment <i>assessdt</i>	Patient ID <i>idn</i>	Patient Letter Code <i>letcode</i>	Correction <i>corrfix</i>
<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>	<input type="text"/>
	<small>mm dd yyyy</small>			

Physical Exam (Continued)

10. Is the patient a sexually active female at least 10 years old or a sexually active male? Yes No
 vssexact **CRA Use Only**

If **No**, skip to signature and certification #.

11. Indicate all types of contraception used (Answer each item):

	Yes	No	
A. Oral contraceptive	<input type="radio"/>	<input type="radio"/>	<i>vscntora</i>
B. Intrauterine contraceptive device	<input type="radio"/>	<input type="radio"/>	<i>vscntiud</i>
C. Depot contraceptives (implants, injectables)	<input type="radio"/>	<input type="radio"/>	<i>vscntdepo</i>
D. Physical barrier (condom, diaphragm)	<input type="radio"/>	<input type="radio"/>	<i>vscntphys</i>
E. Abstinence	<input type="radio"/>	<input type="radio"/>	<i>vscntabs</i>
F. None	<input type="radio"/>	<input type="radio"/>	<i>vscntnon</i>
G. Other	<input type="radio"/>	<input type="radio"/>	<i>vscntoth</i>

Specify *vscntothsp*

Signature: _____

Certif. #: *staffid3* -