

GIRL HEALTH EXAMINATION RECORD

This part to be filled in by parent and reviewed with physician at the time of examination

Name (Last, First, Initial)		Parent or Guardian			Phone	
					()	
PSC /Address	APO/ FPO/city	AP/country	Zip	Birthday	Age	Sex

Insurance Information, please complete the following if not in TRICARE

Carrier	ID Number	Group Number
Member Services Phone Number	Address	

Health History: (Check those that apply)

Diseases	Allergies	Chronic or Recurring Illness	Suggestions From Parent:
<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> German Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Kidney	<input type="checkbox"/> Animals _____ <input type="checkbox"/> Food _____ <input type="checkbox"/> Hay Fever _____ <input type="checkbox"/> Insect Stings _____ <input type="checkbox"/> Medicine/Drugs _____ <input type="checkbox"/> Plants _____ <input type="checkbox"/> Pollen _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Ear Infections <input type="checkbox"/> Heart Defect/Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Asthma <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Musculoskeletal Disorders <input type="checkbox"/> Arthritis <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other _____	<p>My daughter has permission to take or use the following:</p> <input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Sudafed/decongestant <input type="checkbox"/> Benadryl/antihistamine <input type="checkbox"/> Pepto Bismol <input type="checkbox"/> Tums/antacid <input type="checkbox"/> Robitussin/expectorant <input type="checkbox"/> Swimmers' Ear/alcohol-vinegar solution

Please describe conditions and give dates:

Operations or serious injuries: _____

Hospitalizations: _____

Other diseases/disabilities: _____

Comments where applicable:

Fainting _____ Sleep disturbances _____

Bed wetting(bring own materials) _____ Menstrual cramps _____

Constipation _____ Nosebleeds _____

Emotional disturbances _____ Other _____

Specific activities to be encouraged _____ Restricted _____

Special medical or dietary regimen to be followed (specify) _____

This health history is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining physician.

Signature of Parent/Guardian _____ Date _____

Rev. Membership Services, 10/25/2003

GIRL HEALTH EXAM RECORD-2

Name: _____ Date: _____

(This part to be filled in by physician after review of health history with parent/guardian.)

