Shelter program for pregnant & parenting women

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PHYSICAL EXAMINATION REPORT

Please have this report completed by your physician and attach the test results from a "Drug of Abuse Panel" and Pregnancy Test.

Patient's Name: Patient's Birth Date: _______________

Last Period: _______________ Due Date:_______________ Normal Weight:

This young woman appears to be free from communicable disease. ☐ Yes ☐ No

Is this patient considered a "high risk" pregnancy? ☐Yes ☐No

Is this patient presently on medication? ☐ Yes ☐ No

If yes, please list medication and instructions:

Are there any recommendations as to future care, future tests, or treatment(s), and immunization? ☐Yes ☐No

If yes, please describe:

Physician's Signature: ____________________________ Date: ____________