Form Approved
OMB No.**0920**-XXXX
Exp. Date xx/xx/20xx

Physical Health	
Participant ID	_____
Name of Assessor	_____*(free type)*
Name of Data Clerk	_____*(free type)*
Date of assessment	_____ (day – *2 digits*) _____ (month – *2 digits*) _____ (year – *4 digits*)

Head/Fontanelle	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Ears		
Structure	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Appears to hear/responds to sound	☐ Yes	☐ No (please specify): _____*(free type)*
Eyes		
Structure	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Appears to see/responds to visual stimuli	☐ Yes	☐ No (please specify): _____*(free type)*
Skin		
Nevi	☐ No	☐ Yes (please specify): _____*(free type)*
Café au lait spots	☐ No	☐ Yes (please specify): _____*(free type)*
Bruising	☐ No	☐ Yes (please specify): _____*(free type)*
Nose	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Mouth and Throat	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Teeth		

Caries	☐ No	☐ Yes (please specify): _____*(free type)*
Eruption	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Appearance	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Lungs	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Heart	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Femoral pulses	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Abdomen	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Genitalia	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Structure	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Male testes descended (*if applicable*)	☐ Yes	☐ No (please specify): _____*(free type)*
Extremities and Hips	☐ Normal	☐ Abnormal (please specify): _____*(free type)*
Arthrogryposis	☐ No	☐ Yes (please specify): _____*(free type)*
Back	☐ Normal	☐ Abnormal (please specify): _____*(free type)*