

**THE HUGHEN CENTER, INC.**  
2849 Ninth Avenue • Port Arthur, Texas 77642  
Phone: (409)983-6659 Fax: (409)983-6408

**Instructions: This is an interactive form. Please complete all form fields, save the document and email this document to [info@hughencenter.org](mailto:info@hughencenter.org) or fax to 409-983-6408.**

**PHYSICIAN'S REPORT**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Vital Signs: \_\_\_\_\_ Temp: \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration: \_\_\_\_\_ B/P: \_\_\_\_\_

General Health: \_\_\_\_\_

Known or Suspected Allergies: \_\_\_\_\_

History of Convulsive Disorders: Onset: \_\_\_\_\_ Frequency: \_\_\_\_\_

Date of Last Seizure: \_\_\_\_\_ Anti-convulsive Therapy: \_\_\_\_\_

PHYSICAL	NORMAL	ABNORMAL	COMMENT
Skin			
Mouth			
Ears			
Eyes			
Chest-Heart-Lungs			
Gastro-Intestinal			
Kidneys			
Neuro-Muscular			
Bones and Joints			
Reflexes			
Motor			
Sensory			

Dietary Concern: \_\_\_\_\_

List All Medications and How Given: \_\_\_\_\_

Return Visit Recommendation: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City and State: \_\_\_\_\_ Zip: \_\_\_\_\_

*\*Signature required at time of placement.*