PHYSICAL EXAMINATION FORM

To be filled out by Health Care Provider

All full-time, undergraduate students must have a physical exam.

PERSONAL DATA

Name: ____ Date of Birth: ______________________________

Height: ________ Weight: _________ Handed: Right ☐ Left ☐ BP __________ Pulse ______________

Vision: Left Eye _______ Right Eye _______ Both Eyes __________ Glasses or Contacts: ________________________

Are there any abnormalities in the following systems?

	Normal	Describe any abnormalities
MEDICAL		
Head	____________	____________
Eyes/Ears/Nose/Throat	____________	____________
Respiratory	____________	____________
Cardiovascular	____________	____________
Gastrointestinal	____________	____________
Hernia	____________	____________
Genitourinary	____________	____________
Metabolic/Endocrine	____________	____________
Nervous System	____________	____________
Psychiatric (including eating disorders)	____________	____________
Skin	____________	____________
MUSCULOSKELETAL		
Neck	____________	____________
Shoulder	____________	____________
Elbow	____________	____________
Wrist	____________	____________
Hand	____________	____________
Back	____________	____________
Hip	____________	____________

Thigh	____________ __	____ ______
Knee	____________ __	____ ______
Ankle	____________ __	____ ______
Foot	____________ __	____ ______
Scoliosis	____________ __	____ ______

Does this student require a specific diet?
____
____
____
____

Please list any medications (prescriptions & OTC including herbal and dietary supplements) and doses this student is taking:
____
____
____

____

____

List hospitalizations & surgeries (providing details including dates, diagnosis, and complications):
____
____
____
____

List any injuries:
____
____
____
____

Health Provider Name (Print): ____ Date:
____

Health Provider Signature: ____

Street Address: ____

City: ___________________________________ State: __________ Zipcode: __________________

Phone Number: _____________________________________