PHYSICAL EXAMINATION

NAME_____ DATE_____
LAST FIRST MIDDLE

Date of Exam_____ Date of Birth_____

Measurements and Other Findings				
Height:	Weight	Build: Slender: Medium: Heavy: Obese		
Blood Pressure:	Pulse	Respiration:	Temp	

CLINICAL EVALUATION				
Normal	Abnormal	Check each item in appropriate column: "N.A." if not assessed	Provide relevant information for abnormal findings	
		1. Head, Ears, Nose, Throat		
		2. Eyes		
		3. Oropharynx		
		4. Hernia		
		5. Respiratory		
		6. Cardiovascular		
		7. Mammary		
		8. Metabolic / Endocrine		
		9. Genitourinary		
		10. Musculoskeletal		
		11. Neurological		
		12. Psychiatric		

Questions below required to be completed

A. Is student under treatment for any medical or mental health condition that might impair student's participation in the school or in clinical activities: Yes_____ No_____

If YES, please explain: _____

B. Does student have any allergies that faculty or clinical agencies should be made aware of: _____

_____

_____

_____

C. Does this student have communicable disease that would prevent them from participating in the educational program: Yes _____ No _____

If YES, please explain: _____

_____
Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____
Print Name of Physician/Physician Assistant/Nurse Practitioner Telephone

_____
Office Address City ST Zip