Student Name ______________________ **Date of Birth** ____________

Physical Exam

Please have this form completed and signed by your healthcare provider (physician, physician assistant, or nurse practitioner). **Office stamp required.**

Current Meds ______________________

____

Allergies ______________________

General Appearance: ____________ Height ______ Weight ______ Temp ______

(Female only) LMP: ____________ Pulse ______ Resp ______ B/P ______

Check if normal or describe abnormal findings:

- ☐ Skin: ____________
- ☐ Head: ____________
- ☐ Eyes: ____________
- ☐ Ears: ____________
- ☐ Nose: ____________
- ☐ Mouth/Throat: ____________
- ☐ Neck/Thyroid: ____________
- ☐ Nodes: ____________
- ☐ Chest: ____________
- ☐ Heart: ____________
- ☐ Lungs ____________
- ☐ Back: ____________
- ☐ Abdomen/Hernia: ____________
- ☐ Genitalia: ____________
- ☐ Extremities/Musculoskeletal: ____________
- ☐ Neuro: ____________

FINDINGS

____

____

____

PLAN

____

____

____

Immunizations given (during this visit): ______________________

Pending laboratory results, and when expected: ______________________

Restrictions for University or clinical work setting, if any: ______________________

Clinician Signature ______________________

Print Name and Title ______________________

Address ______________________

City/ State/ Zip ______________________

Telephone ______________________

Exam Date ______________________

8/2/2017