**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 _____

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 _____ Exam Date _____

Print Name and Title _____

Address _____

City/ State/ Zip _____

Telephone _____

**Office Stamp Required**