

Student Physical Examination

Health Form

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address:  
Date of Birth:   
City/State/Zip:

Health Care Provider Information

Name:

License #:

Address:

**Physical Examination**

| **System** | **Abnormalities**  **Yes** | **Abnormalities**  **No** | **If yes, describe** |
| --- | --- | --- | --- |
| Head, Ears, Nose, Throat |  |  |  |
| Respiratory |  |  |  |
| Cardiovascular |  |  |  |
| Gastrointestinal |  |  |  |
| Hernia |  |  |  |
| Eyes |  |  |  |
| Genitourinary |  |  |  |
| Musculoskeletal |  |  |  |
| Metabolic/Endocrine |  |  |  |
| Neuropsychiatric |  |  |  |
| Skin |  |  |  |

Is there loss or seriously impaired function of any organ? Yes\_\_\_\_\_\_\_\_\_No

Please identify any recent illness, operations, allergies, current limitations or pertinent medical history:

Are you presently on any prescribed medication(s)? Yes No

If yes, please list medication name(s):

Any general comments:

Please list any allergies to medicine(s) or environmental influences:

Limitations for physical activity? Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_   
(If “yes”, please explain)

Provider’s Signature

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

Please print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_