



## Physical Examination

**TO THE EXAMINING PHYSICIAN:** Please review the student's history and complete the physician form. Please comment on all positive answers. The information supplied will be used as a background for providing health care. This information is strictly for use of the Health Service and will not be released without the student's consent.

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_

Height \_\_\_\_\_ inches Weight \_\_\_\_\_ inches B.P. \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_ /min

Corrected Vision Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_ Right \_\_\_\_\_ Hearing (gross):  
Left \_\_\_\_\_

**URINALYSIS**

Sugar \_\_\_\_\_  
Albumin \_\_\_\_\_  
Micro \_\_\_\_\_  
MEMATOCRIT (IF INDICATED)  
SICKLE CELL  
\_\_\_\_\_ %

**HISTORY OF IMMUNIZATIONS**  
(NC residents may submit high school immunization record)

VACCINE	DATE	DATE	DATE	DATE	
DTP	#1	#2	#3	#4	
Td or TETANUS BOOSTER					
POLIO, oral					
RUBEOLA (measles, MMR)			Disease Date		
MUMPS (MMR)					
RUBELLA (German measles, MMR)					

**Are there abnormalities of the following systems? Describe fully. Use additional sheet if necessary**

	YES	NO	
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatry			
Skin			
Mammary			

- A. Is there loss or seriously impaired function of any paired organ? Yes \_\_\_\_\_ No \_\_\_\_\_  
 B. Have you any general comments?  
 \_\_\_\_\_

- C. Do you have any recommendations regarding the care of this student? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain \_\_\_\_\_

- D. Do you have any recommendations for physical activity (Phys. Ed., Intramurals, etc?) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_

- E. Is the student now under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

Tuberculin Skin Test (within one year)  
 Date \_\_\_\_\_ Positive  Negative

Chest x-ray (if skin test is positive)  
 Date \_\_\_\_\_ Report \_\_\_\_\_

\_\_\_\_\_  
 Signature of Physician/Physician Assistant/ Nurse Practitioner

OFFICE / CLINIC STAMP WITH ADDRESS  
 AND TELEPHONE NUMBER

Date \_\_\_\_\_