

OFFICE OF STUDENT HEALTH

Name _____

Date: _____

Physical Examination

Vital Signs: BP _____ / _____, Pulse _____, Ht. _____", Wt. _____ lbs.

Check abnormal items and describe in detail.

Normal	Abnormal	
Skin: <input type="checkbox"/>	<input type="checkbox"/>	(hair/nails/scars)
Eyes: <input type="checkbox"/>	<input type="checkbox"/>	(lids/pupils/conjunctivitis/cornea/fundi)
Ears/Nose: <input type="checkbox"/>	<input type="checkbox"/>	(pinna/canal/drum/hearing/nasal mucosal)
Oropharynx: <input type="checkbox"/>	<input type="checkbox"/>	(teeth/gums/mucosal/tonsils/pharynx)
Neck: <input type="checkbox"/>	<input type="checkbox"/>	(motion/thyroid/masses/nodes)
Heart: <input type="checkbox"/>	<input type="checkbox"/>	(pulses/rate/rhythm/murmurs)
Breasts: <input type="checkbox"/>	<input type="checkbox"/>	(fibrocystic changes/masses)
Lungs: <input type="checkbox"/>	<input type="checkbox"/>	(breath sounds)
Abdomen: <input type="checkbox"/>	<input type="checkbox"/>	(scars/tenderness/bowel sounds/masses/organs)
Ortho: <input type="checkbox"/>	<input type="checkbox"/>	(spine/joints/mobility)
Extremities: <input type="checkbox"/>	<input type="checkbox"/>	(peripheral pulses/venous return)
Neuro: <input type="checkbox"/>	<input type="checkbox"/>	(mental status/speech/motor/sensory/reflexes/coordination)
Male Genital: <input type="checkbox"/>	<input type="checkbox"/>	(testicular/hernia/lesions)
Pelvic/Rectal: <input type="checkbox"/>	<input type="checkbox"/>	Pap last performed (Date) _____ <input type="checkbox"/> Deferred

Assessment:

Physician/Health Care Provider Signature:

Physician/Health Care Provider Name (please print) _____

Address: _____

Phone: _____