

# PHYSICAL REPORT

(3)

(To be completed by licensed M.D., D.O., Nurse Practitioner or Physician Assistant)

Date \_\_\_\_\_

To the examining physician: Please review the student's history on page 2 and complete the Physician's Report below. Positive answers should be supplemented with additional information as appropriate.

Student's last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female

\_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

### Please check whether physical findings are normal or abnormal:

		normal	abnormal
1	Skin		
2	Eyes		
3	Ears		
4	Nose/Sinuses		
5	Mouth/Throat/Dental		
6	Neck/Thyroid		
7	Heart		
8	Lungs/Chest		
9	Breasts		
10	Abdomen		
11	Nervous System		
12	Extremities/Joints		
13	Back		
14	Genitourinary System		
15	Mental Status		

**Eyes**  
Glasses Yes \_\_\_\_\_ No \_\_\_\_\_  
Contacts Yes \_\_\_\_\_ No \_\_\_\_\_

**For Female Patients:** (not required)  
Date of last gynecological exam \_\_\_\_\_  
Pap result \_\_\_\_\_ N/A

Please explain any abnormal findings on physical exam:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all allergies \_\_\_\_\_  
\_\_\_\_\_

- Recommendations for physical activity  Unlimited
- (P.E., Intramurals)  Limited (explain below)
- Recommendations regarding the care of this patient (explain below)
- Patient now under treatment for medical or emotional condition (explain below)

### Please comment on any abnormal condition the patient has had or is being treated for:

**TO THE HEALTH PROVIDER:** Please turn over this page, complete the tuberculosis screening tool (**REQUIRED**) and sign the physical report.

(OVER)