PHYSICAL EXAMINATION RECORD

PHYSICAL EXAMINATION (To be completed by Medical Provider)

Physical Exam Date_____

LAST NAME **FIRST NAME** **MIDDLE NAME** **DATE OF BIRTH (mo/day/yr)** **STUDENT ID#**

TEMP **RESP** **PULSE (sitting)** **BLOOD PRESSURE (sitting)** **HEIGHT** **WEIGHT** **BMI (Body Mass Index)**

VISION: Right Eye 20/ **Left Eye 20/** **Corrected: Right Eye 20/** **Left Eye 20/**

MEDICALHISTORY

ALLERGIES: **MEDICATIONS:**

PHYSICAL EXAM

General Appearance/Mental Status: _____

Check appropriate answer	Normal	Abnormal	Comment on abnormalities
Head/face/scalp			
Neck/nodes/ thyroid			
Eyes/Ears/Nose/Sinuses			
Mouth and teeth			
Pharynx and tonsils			
Lungs and chest			
Breasts			
Heart (size, rhythm, murmurs)			
Abdomen (scars, hernia, mass)			
Genitourinary (pelvic in females)			**LNMP___/___/___**
Anus, rectum (prostate in males)			
Extremities			
Spine and musculoskeletal			
Peripheral vascular system			
Skin and lymphatics			
Neurological, reflexes			

LABORATORY DATA

TUBERCULOSIS SCREENING` **Annual PPD-Mantoux tests are required.** **Please document dates for the last two PPD readings:**

Date skin test placed____/____/_____Date skin test read___/_____/___ Reading in mm induration: _ Date skin test placed_____/____/_____Date skin test read_____/____/____ Reading in mm induration: _____

A Two step PPD-Mantoux is required for all Health Professions students if their last PPD was placed > one year ago.

(The second PPD must be placed no earlier than a week after the first PPD but no later than 3 weeks after the first PPD is placed)

Date 1st PPP Placed: ___/___/___ Date PPD Read: ___/___/___ Reading in mm induration: _____mm

Date 2nd PPD Placed: ___/___/___ Date PPD Read: ___/___/___ Reading in mm induration: _____mm

If PPD is positive, you must submit a copy of a chest x-ray report done within the last six months.

Date of Chest X-Ray_____Result:_____**RESTRICTED ACTIVITY:No □ Yes □** **Reason for Restriction:** _____

Provider's Signature and Title: **Date:**

_____**Provider's Name and Title:** **Office/Clinic**

Phone No: _____

_____**Office/ Clinic**

Name **Office/Clinic Address** **City/State**