

Physical Examination for Health Profession Students

Name: _____ Date of Birth: ____/____/____ Date of Examination: ____/____/____

Medical History & Physical (To be completed by examining health care practitioner within 12 months prior to 1st day of classes)**Medical History**

Medical: _____

Surgical: _____

Family History: _____

Review of Systems: _____

Allergies: _____

Medications: _____

Habits (i.e. tobacco, thc, alcohol): _____

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____/_____/_____ Vision: Corrected _____ Uncorrected _____

Lymph Nodes: _____

Ears, Nose & Hearing: _____

Neck: _____

Breasts: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Identified Health Problems: _____

♦ Based on history and physical examination, are any special accommodations necessary? ☐ Yes ☐ No

Explain: _____

♦ I confirm, based on history and physical examination, that there are no health impairments (including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter behavior) that would be of potential risk to patients or personnel, or which might interfere with the performance of the above-named practitioner's responsibilities.

If you do not concur, please explain: _____

Health Care Practitioner Name (print or stamp)	Signature	Date
Address		Phone