# Physical Exam Form

**This form must be completed by an MD/DO, NP, or PA who is not a relative. Only this form will be accepted as documentation of a physical exam.**

## This section to be completed by the student:

| | | | | | |
|---|---|---|---|---|---|
| **Last Name** | | **First Name** | | **Middle Initial** | |
| **UNI** | | **Date of Birth** | | **School/Program** | |
| **Full-time** | | **Part-time** | | **Telephone Number** | |

## This section to be completed by a medical provider:

Visual Acuity: *(with correction, if any)* OD _____ OS _____ Correction? □ Yes □ No

Height *(inches)* _____ Weight *(pounds)* _____ BP _____ Pulse _____

| | Normal | Abnormal | Not Done | If abnormal, please explain |
|---|---|---|---|---|
| **General Appearance** | | | | |
| **Head** | | | | |
| **Eyes** | | | | |
| **Ears, Nose, Throat** | | | | |
| **Neck** | | | | |
| **Lymph Nodes** | | | | |
| **Breasts** | | | | |
| **Heart** | | | | |
| **Lungs** | | | | |
| **Abdomen** | | | | |
| **Pelvic Exam** | | | | |
| **GU Exam** | | | | |

Name _____ UNI _____

| | | | | |
|---|---|---|---|---|
| **Rectal Exam** | | | | |
| **Extremities** | | | | |
| **Neurological Exam** | | | | |

This student is in good health and is free of contagious disease. To the best of my knowledge, the student is free from any health impairment which is of potential risk to patients or which might interfere with the performance of assigned duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior. ☐ Yes ☐ No

Does this student require ongoing medical care? ☐ Yes ☐ No

Specify:

Provider's Printed Name _____ Exam Date_____

Provider's Signature _____ License Number_____

Clinician/Practice Stamp *(required)*