

PHYSICAL EXAMINATION

Program of Study _____

SEX: M ____ F ____

LAST NAME _____ **FIRST NAME** _____ **MIDDLE** _____ **BIRTH DATE** _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. Vision _____ right _____ left

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician’s assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. All blanks on the physical examination form must be completed. The completed form must be uploaded to the student’s compliance account within 90 days of published compliance deadline. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college’s administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements.

REVIEW OF SYSTEMS:

Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurologic			
Dermatologic			

ALLERGIES: _____

Is the patient now under treatment for any medical or psychological condition? NO ____ YES ____ (explain) _____

Does this patient have any active prescriptions, even if for occasional use only? NO ____ YES ____ (list) _____

Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO ____ YES ____ (list) _____

Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO ____ YES ____ (please comment)

NOTES/COMMENTS: _____

Healthcare Professional’s Name/Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE OF PROVIDER: _____ **DATE:** _____