# Health Service Physical Exam Form

## STUDENT INFORMATION

Name: ________________________________  Date: _______  Age: _______  Date of Birth: ____________

Address: __________________________________________________________ State: ___________  ZIP: ______________

Height: ___________  Vision: R_____/_____ corrected □ / uncorrected □  Glasses? Yes □  No □

Weight: ___________  L_____/_____ corrected □ / uncorrected □  Contacts? Yes □  No □

Pulse: ___________  Blood Pressure: ________/_______

List of Allergies to Medication

List of Medications and Supplements: _________________________________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes, Ears, Nose, Throat, Mouth &amp; Teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck, Thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest &amp; Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia-Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testicular Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal (ROM, strength, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>neck □  shoulders □  arms □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hands □  back □  hips □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>knees □  feet □  legs □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of last gynecological exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalizations  Yes □  No □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological or Emotional Problems  Yes □  No □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity Restrictions last 5 years  Yes □  No □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies/Asthma?  Yes □  No □</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Health Services Physical Exam Form must be completed by a physician or a nurse practitioner/physician’s assistant.
Rev. 12/2017
Continued from front

Does patient have or ever had any of the following health problems: (Please circle)
Cancer - Head Injury – Neck or Back Injuries - Convulsions or Epilepsy - Anemia – Diabetes – Chest paint with Exercise – Dizziness or Fainting with Exercise – Food Allergies – Seasonal or Environmental Allergies.

Explanation: ____________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Does patient use tobacco products (cigarettes, cigars, snuff, e-cigarette?) Yes □   No □

If yes, have you discussed the risk? Yes □   No □

Has patient been offered education about the use of alcohol, steroids, dietary supplements and other drugs; including misuse/abuse of prescription medication? Yes □   No □

Have you discussed safe sex practices with patient? Yes □   No □

Please comment on whether further evaluation or care is needed: __________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Recommendations for Physical Activity: Exercise programs & use of fitness equipment. Unlimited □   Limited □

Intercollegiate & Recreational Sports: Is this student capable of participating in a full program of college study, including participation in intercollegiate sports/intramural or club sports? Yes □   No □

□ Cleared after completing evaluation/rehabilitation for: __________________________________________________________

*Please note that all student participating in intercollegiate athletic programs at PSU must complete specific medical forms. They can be found under Athletic Training medical forms on the PSU Athletics webpage.

Recommendations:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

PRACTICIONER INFORMATION

Clinician’s Signature: _________________________________ Date: ______________

Clinician’s Name, Address & Telephone (please print):

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Plymouth State University, Student Health Services
17 High St., MSC 45, Plymouth, NH 03264
Telephone: 603-535-2350

The Health Services Physical Exam Form must be completed by a physician or a nurse practitioner/physician’s assistant.
Rev. 12/2017