

Springfield College Health Center
PHYSICAL EXAMINATION

Student's Name: _____ **Date of Exam:** _____

Date of Birth: _____ **Social Security Number:** _____ **Identification #** _____

Sex (circle one): Male Female **Sport** (student athletes only): _____

The Physical Examination must be completed by a health care provider (MD, DO, NP, PA)

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____

LABORATORY TESTS: (Hgb / HCT and UA are preferred but not required.)

Hgb or HCT _____

Urinalysis: glucose: _____ protein: _____ blood: _____

Other: _____

VISION	<u>RIGHT</u>	<u>LEFT</u>
Uncorrected	20 /	20 /
Corrected	20 /	20 /
Contact Lens? (Circle one)	YES NO	
Glasses? (Circle one)	YES NO	

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
Skin and Lymph Nodes			
Head, Neck, Thyroid			
Eyes			
Ears and Hearing			
Nose, Sinuses, Throat			
Mouth, Teeth, Gingiva			
Lungs and Chest			
Heart and Cardiovascular			
Abdomen			
Genitalia, Hernia			
Neurological Exam			
Musculoskeletal: ROM, strength, etc.			
Spine			
Shoulder			
Elbow			
Wrist			
Hand			
Hip and Pelvis			
Knee			
Ankle			
Foot			

Is this individual currently under treatment for any medical or emotional condition? YES NO
If YES, please specify: _____

Do you have any recommendations regarding the care of this individual? YES NO
If YES, please specify: _____

RECOMMENDATION FOR PHYSICAL ACTIVITY: Unlimited _____ Limited _____

If limited, please specify: _____

Health Care Provider's Signature: _____ Date: _____

Health Care Provider's Printed Name: _____

Address: _____

Telephone: _____