PHYSICAL EXAMINATION FORM

PERSONAL HISTORY  Do you have now or have you ever had any of the following? Please check all that apply.

9. ☐ Cystic fibrosis 18. ☐ Impaired mobility / paralysis 27. ☐ Sickle Cell Disease / Trait 36. ☐ Other___

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates): __________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

CURRENT MEDICATIONS: List:
________________________________________________________________________________________

ALLERGY: TO MEDICATION: ☐ Penicillin  ☐ Sulfur  ☐ Other Medication (name)__________________

☐ ENVIRONMENTAL  ☐ FOODS (name)________________________

EPI-PEN: HAVE YOU EVER NEEDED IT? ☐ YES  ☐ NO  DO YOU CARRY EPI-PEN? ☐ YES  ☐ NO

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<thead>
<tr>
<th></th>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Living</th>
<th>Age of Death</th>
<th>Cause of Death</th>
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<tbody>
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<td>Father</td>
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<td>Sisters</td>
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FAMILY HISTORY: List family members with health problems: i.e. cancer, diabetes, heart disease, Marfan Syndrome,
________________________________________________________________________________________
________________________________________________________________________________________

Rev.6/2015 Please see other side for Physical Exam Report to be completed by MD or NP
Student's Name_________________________   LAST NAME   FIRST NAME   DATE OF BIRTH

Vision: R 20/_____   L 20/_____   Corrected Vision: R 20/_____   L 20/_____

Height:_______   Weight:_______   BP:_______   Pulse:_______

Tuberculosis Test: PPD

- Date placed: _____/_____/
- Date read: _____/_____/
- Result: _______mm induration

Chest X-ray (if PPD Positive) attach typed X-ray copy

- Date of Chest X-ray ___________
- Result of Chest X-ray ___________
- Student receiving therapy:_______
- Yes  No  Refused

Urinalysis:

- Glucose___  Protein_____
- Leucocytes_____  Blood_____  

Immunization Dates:

- Tdap ___________
- Td ___________

Attach Immunization record

for other Vaccines received

SYSTEM | NORMAL | DESCRIBE ABNORMALITY
---|---|---
Anemia (type) | | |
Cardiovascular | | |
Chest and Breasts | | |
Gastrointestinal | | |
Genitourinary | | |
HEENT | | |
Metabolic / Endocrine | | |
Musculoskeletal | | |
Neurological | | |
Psychological | | |
Respiratory | | |
Skin | | |

CURRENT & CHRONIC PROBLEMS: _______________________________________________________
_________________________________________________________________________________

PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY:  □ Unlimited  □ Limited (specify):__________

PHYSICIAN OR NP’s SIGNATURE: __________________________________________________________

PRINT PHYSICIAN or NP’s NAME: _______________________________________________________

State / License #________________________________________ Date of Physical Exam:__________

Address__________________________________________________________________________ Date Form Signed: ___________

Use Office Stamp:

MAIL COMPLETED FORM TO:  
COLLEGE OF MOUNT SAINT VINCENT  
Health Center  
6301 Riverdale Avenue  
Riverdale NY 10471

Rev.6/2015