

PHYSICAL EXAMINATION FORM 2008 – 2009  
Neil Hodgson Woodruff School of Nursing

This is a confidential form that must be filled out by the student and his/her primary care physician. The student will not be fully registered and enrolled until BOTH the front and back of this form are completed, signed, and returned to Emory University Student Health Services. Please return this form to:

**Emory University Student Health Services**  
Attention: Immunization Nurse  
1525 Clifton Road NE  
Atlanta, GA 30322  
(404) 727-7551

Student's Name: \_\_\_\_\_ Emory ID#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Country: \_\_\_\_\_

Gender:  Male  Female  Transgender (please elaborate): \_\_\_\_\_

Date of Birth (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Positive PPD Test/Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Behavior Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Urinary Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use (current or past)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		<input type="checkbox"/>
						Other: _____		<input type="checkbox"/>

Comments (please explain any YES answers above): \_\_\_\_\_

List all allergies: \_\_\_\_\_

Surgeries (with dates): \_\_\_\_\_

Previous hospitalizations (with dates): \_\_\_\_\_

Current medications: \_\_\_\_\_

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PHYSICAL EXAMINATION

(This page must be completed and signed by your physician, nurse practitioner or physician assistant.)

Patient's Name: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temp: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ RR: \_\_\_\_\_

Vision: OD \_\_\_\_\_ OS \_\_\_\_\_ OU \_\_\_\_\_ Without correction: \_\_\_\_\_

OD \_\_\_\_\_ OS \_\_\_\_\_ OU \_\_\_\_\_ With correction: \_\_\_\_\_

	Normal	Abnormal	Comments
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
GU	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

How long and on what basis have you known this patient?

Months: \_\_\_\_\_ Years: \_\_\_\_\_  This visit only

Professional basis  Personal basis

To your knowledge, does this patient have any significant medical problems?  Yes  No

Explain: \_\_\_\_\_

To your knowledge, does this patient have any emotional, psychological or psychiatric problems?  Yes  No

Explain: \_\_\_\_\_

Do you know of any physical or psychological reason why this student would not be able to withstand the rigors of nursing school education?  Yes  No

Explain: \_\_\_\_\_

Labs (if indicated): CXR \_\_\_\_\_ U/A \_\_\_\_\_  
CBC or H/H \_\_\_\_\_ Pap \_\_\_\_\_  
Other \_\_\_\_\_ Other \_\_\_\_\_

Physician/NP/PA Name: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Address: \_\_\_\_\_

Physician/NP/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_