OHIO DOMINICAN UNIVERSITY

PHYSICAL EXAMINATION FORM

Section I: To be completed by STUDENT:

Name: ____ DOB: __________________________

Address: ____ Phone: __________________________

____

Health History: Please complete the following information. In the past 12 months have you experienced any of the following:

	No	Yes	If Yes, Explain		No	Yes	If Yes, Explain
Recent weight loss or gain				Indigestion, nausea, vomiting, diarrhea, constipation			
Fatigue, fever, sweats				Frequent bladder infections or excessive urination			
Difficulty with vision or hearing				Abnormal menses or vaginal discharge (female)			
Freq. or unusual headache				Penile discharge or testicular lumps (male)			
Difficulty swallowing, hoarseness, sore throat				Joint pain, muscle weakness			
Swollen glands or lumps in neck, groin, axilla				Neck or back pain			
Dizziness, fainting				Numbness, weakness of arms or legs			
Chronic cough, wheezing, short of breath				Excessive bruising or bleeding			
Chest pain, palpitations or ankle swelling				Depression, anxiety, insomnia			

Other
____

Section II: To be completed by PHYSICIAN, CNP OR PA-C:

Pertinent Family History:

Pertinent Social History:

Under Current Medical Care: ______ NO ______ YES If YES, please explain:

Current Medications: Allergies:

PHYSICAL EXAMINATION

Wt __________ Ht __________ BP __________ Pulse __________ Vision: OS 20/_________ OD 20/_________

	Check if WNL	Abnormality noted and comments
Skin and lymphatics		
Head, neck		
Nose and sinuses		
Mouth and throat		
Ears		
Eyes		
Lungs		
Heart		
Vascular system		
Abdomen		
GU system		
Neurologic		

Name of examiner (print) ____

Date ____________________________ Telephone ____

Address ____

____

Signature ____