

PHYSICAL EXAMINATION

Must be completed within twelve months of enrollment or you may attach a signed copy of your most recent physical examination.

Student Name _____

Date of Exam _____

Height _____ Weight _____ BP _____ Pulse _____

Hearing: Right _____ Left _____

Vision: Without correction: Right 20/_____ Left 20/_____

With correction: Right 20/_____ Left 20/_____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Respiratory		
Breast Cardiovascular		
Gastrointestinal		
Genitourinary Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Lab Work (if indicated): Hgb/Hct: _____ Cholesterol: _____ Urine: Glucose: _____ Protein: _____ Micro: _____

CURRENT MAJOR & CHRONIC PROBLEMS

ACUTE & MINOR PROBLEMS

If the student is under care for a chronic condition or serious illness please provide additional clinical reports to assist us in providing continuity of care.

Additional comments and recommendations: _____

Please list any special **DIETARY REQUIREMENTS**: _____

Please list all **ALLERGIES** (including medications, insect venom, foods, etc): _____

Type of reaction _____

Please list all **MEDICATIONS** currently being taken (include OTC's, contraceptives): _____

Recommendations for physical activity: unlimited limited (specify) _____

Medical Provider (please print) _____

Address _____

Phone (____) _____ Fax (____) _____

Provider's Signature _____

Upload completed form to your UML

health portal: <https://patient-uml.medicatconnect.com/>



Telephone: (978) 934-6800