EMORY UNIVERSITY | Student Health Services
Campus Life

PHYSICAL EXAMINATION FORM
Allied Health, Medical and Nursing Students Only

All incoming medical, nursing and allied health students must return this completed, signed form PRIOR TO MATRICULATION through one of the following methods:

- Upload the form to your Patient Portal (**preferred**) **or**
- Email a pdf to immunizations-shs@emory.edu **or**
- Fax to: 404-727-7343
- Mail to: Emory University Student Health Services
  Attention: Immunization Department
  1525 Clifton Road NE, Atlanta, GA 30322

Student's Name: _____ Emory ID#: _____

Street Address: _____

City: _____ State: _____ ZIP: _____ Country: _____

Gender: ❒ Male ❒ Female ❒ Transgender: MTF_____ FTM_____ Other_____

Date of Birth (mm/dd/yyyy): _____/_____/_____

❒ School of Medicine ❒ School of Nursing ❒ Allied Health (specify program :_____)

Do you now have or have you ever had:

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

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:_____ BMI: _____ Temp:____ BP:_____ Pulse:____ RR:_____

Vision: OD_____ OS_____ OU_____ Without correction:_____

OD_____ OS_____ OU_____ With correction:_____

	Normal	Abnormal	Comments
HEENT	❒	❒	_____
Neck	❒	❒	_____
Lungs	❒	❒	_____
Heart	❒	❒	_____
Abdomen	❒	❒	_____
GU (if indicated)	❒	❒	_____
Extremities	❒	❒	_____
Neurologic	❒	❒	_____
Adenopathy	❒	❒	_____
Vascular	❒	❒	_____
Skin	❒	❒	_____
Psychiatric	❒	❒	_____

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 his/her program of study? ❒ 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: _____

2020-21 Update