



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 (dd/mm/yyyy):

Medical School Student School of Nursing Allied Health Student (Specify Program:)

Do you now have or have you ever had:

Table with 3 columns of medical conditions and 2 columns of 'No' and 'Yes' checkboxes.

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 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: \_\_\_\_\_