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 **or**
- 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:

	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:________ Temp:________ BP:________ Pulse:________ RR:________

Vision: OD_______ OS________ OU________ Without correction:__________________

OD_______ OS________ OU________ With correction:__________________

	Normal	Abnormal	Comments
HEENT	❒	❒	
Neck	❒	❒	
Lungs	❒	❒	
Heart	❒	❒	
Abdomen	❒	❒	
GU	❒	❒	
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:______________

2021/22 update