1912 SAINT JOSEPH'S COLLEGE

HEALTH AND WELLNESS CENTER

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PLEASE PRINT

PHYSICAL EVALUATION

To the Physician: This student has been admitted, please review the student history and complete this physician's form commenting on all positive or abnormal findings. All items are required.

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF EXAM

DATE OF BIRTH	STUDENT ID #

Height________ Weight_______ BMI________

Blood Pressure: Systolic_______ Diastolic________

Pulse: __Regular __Irregular

Visual Acuity: ___Normal ___Abnormal

Uncorrected: RT 20/ LT 20/ Corrected: RT 20/ LT 20/

Does the student wear glasses/contact lenses? __Yes __No

Is color vision normal? __Yes __No

Physical Examination	Normal	Abnormal Please explain		Normal	Abnormal Please explain
Skin, hair and nails			Extremities/Musculoskeletal		
Head, eyes, ears, nose, sinuses			Genitalia/Hernia (male only)		
Mouth, throat, dentition, neck			Neurologic		
Heart			Psychiatric		
Lungs			Lymph nodes		
Abdomen			Other:		

Recommendations for physical activity: ____ Limited ____ Unlimited
Explain: ____

Is there loss or seriously impaired function of any organ? __Yes __No
Explain:___________

Is student now under treatment for any physical or emotional problems? __Yes __No
Explain: ____

PHYSICIAN'S SIGNATURE ____

PHYSICIAN'S NAME (printed) ____

Address ____

____

Date ________________________ APR2020