PHYSICAL EXAMINATION FORM

This is a confidential form that must be filled out by the student and his/her primary care physician. The student will not be fully registered and enrolled until BOTH pages of this form are completed, signed, and returned. Please return this form to:

Emory University School of Nursing
Attention: Nicole Ingram
1520 Clifton Road NE
Atlanta, GA 30322

AND

Emory University Student Health Services
Attention: Molly Mitchell
1525 Clifton Road NE
Atlanta, GA 30322

Student's Name:____ Emory ID#: ________________

Street Address:____

City:____________________________________ State:______ ZIP:____________ Country:______________

Gender: ❒ Male ❒ Female ❒ Transgender (please elaborate): ________________________________

Date of Birth (dd/mm/yyyy): _____/_____/____________ SSN: ___________--_______--____________________

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 nursing school education? ❒ 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:______________