Physical Exam – To be completed by healthcare provider

This student has been accepted to SAIC. The information below is confidential and will not affect the student's admission status. This form is maintained by Health Services.

Student's Name (Print): ____Date of Birth: _______________
Last First MI Month/Day/Year
Height _________ Weight ___________ BMI___________ BP ____________ Heart Rate ___________

Vision: Right __________Left _________(indicate: with corrective lenses/ without corrective lenses)

System	***Normal***	**Please describe abnormal findings.**
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System (murmur, click)		
Abdomen (rectal if indicated)		
Genito-Urinary		
Pelvic (if indicated)		
Lymphatic		
Musculo-Skeletal		
Neurological		
Endocrine		
Psychological		

Chronic Health Conditions: ____

Acute Problems: ____

Current Medications: ____

Allergies: ____

Physical Limitations or Restrictions: ____

____

Recommended Follow Up/Health Maintenance Plan: _____________________________________

____

Relevant lab results (may attach copies):____

NAME AND SIGNATURE OF HEALTH CARE PROVIDER VERIFYING ABOVE INFORMATION

Provider's Printed Name____Stamp:
MD/DO/NP/PA

Signature____Date_______________

Address____

Phone Number (________)____________________________________