# Saint Mary-of-the-Woods College

## Health Examination by Physician 2014-2015

**Confidential**

Family Name (Last Name) First Name Middle Name Date of Birth

### Physical Findings

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Hearing: Right _____ Left _____ Gross Exam Today: Y N If no, date of exam: _____

Vision: Uncorrected Rt. 20/____ Lt. 20/_____ Corrected Rt. 20/____ Lt. 20/_____

| Check Normal or Abnormal for each of the following: | Normal | Abnormal | Comments |
|---|---|---|---|
| 1. Head, neck, face, scalp | _____ | _____ | _____ |
| 2. Nose and sinuses | _____ | _____ | _____ |
| 3. Mouth and throat | _____ | _____ | _____ |
| 4. Teeth and gingiva | _____ | _____ | _____ |
| 5. Ears-general (canals, etc.) | _____ | _____ | _____ |
| 6. Tympanum (perforations, etc.) | _____ | _____ | _____ |
| 7. Eyes (lids, conjunctiva, etc.) | _____ | _____ | _____ |
| 8. Pupils and ocular motion | _____ | _____ | _____ |
| 9. Lungs, chest, and breasts | _____ | _____ | _____ |
| 10. Heart (include estimate of cardiac function | _____ | _____ | _____ |
| 11. Vascular System (include varicosities) | _____ | _____ | _____ |
| 12. Abdomen and viscera (include hernia) | _____ | _____ | _____ |
| 13. Anorectal | _____ | _____ | _____ |
| 14. Endocrine system | _____ | _____ | _____ |
| 15. G.U. system | _____ | _____ | _____ |
| 16. Upper extremities | _____ | _____ | _____ |
| 17. Lower extremities | _____ | _____ | _____ |
| 18. Feet | _____ | _____ | _____ |
| 19. Spine, musculoskeletal | _____ | _____ | _____ |
| 20. Skin and lymphatic, acne | _____ | _____ | _____ |
| 21. Neurologic | _____ | _____ | _____ |
| 22. Psychiatric (specify mode of treatment) | _____ | _____ | _____ |

Has this patient ever, to your knowledge, been treated for nervous or emotional disorder? _____

Is the student receiving medication regularly? _____ If so, what? _____

How long have you known the patient? _____

Check **one or the other** of the following statements:

_____ Student *may* participate in unlimited physical education, intramural activities, and intercollegiate athletics.

_____ Student must be in a restricted or *adapted* physical education program designed for physical limitation.

Indicate specific limitation _____

**Please type or print:**

Physician's Name: _____ Physician's Signature: _____

Office Address: _____

Phone: _____ Date of Examination: _____