PHYSICAL EXAMINATION FORM

WPI Health and Wellness Services p.508-831-5520 f. 508-831-5953

Name: _____Date of Birth: _____Date of Exam: _____

Does applicant have any past/current medical problems? ___YES ___ NO Gender: _____ Preferred Gender Pronoun: _____
If yes, please describe: _____

Does the applicant have a history of past/current emotional or psychological problems? ___YES ___NO
If yes, please describe: _____

Has applicant been hospitalized in the past? ___YES ___ NO
If yes, please describe: _____

List Pertinent Family History: _____

Current Medication(s) with dosage: _____

Allergies: (medication, food, or other):_____

Height_____ Weight_____ BMI _____ Pulse_____ BP _____/_____ Vision R 20/_____ L 20/_____

	NORMAL	ABNORMAL FINDINGS
Appearance		
Skin		
HEENT		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurological		
Psychological		

- The patient may fully participate in physical education and club sports. ___YES ___ NO

*** If NO, please list restrictions._____

- Does the patient require additional follow up? . ___YES ___ NO

*** If YES, please provide treatment plan. _____

_____

(Submit additional information as necessary.)

Healthcare provider: _____
Print Last Name, First Name, NP/ PA/ MD/DO

Address_____

Phone #: _____ Fax #: _____

Signature of Healthcare Provider:

_____

Date