PHYSICAL EXAMINATION FORM

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

Name: _____Date of Birth: _____ Date: _____

Does applicant have any past/current medical problems? ____Yes___ No Gender:____ Preferred 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
History of Varicella Disease? ___Yes ___ No
Review, sign and date Massachusetts Tuberculosis Risk Assessment. Risk factors present? ___ Yes ___ No
If risk factor(s) present, complete required testing on the immunization record.
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		

Healthcare provider: _____

Please print Last First NP, PA, MD, DO

Address_____

Phone #: _____ Fax #: _____

Signature of Healthcare provider: _____

- The student may fully participate in physical education and club sports __YES ___ NO
- If no please list restrictions_____
- The applicant ___should____should not have additional____ medical___psychological follow up. Please contact Student Development and Counseling at 508-831-5540 if psychological follow up recommended.