





**Physical Examination Form**

Student Name: \_\_\_\_\_ Sex:  M  F Birth date: \_\_\_\_\_

Program Location: \_\_\_\_\_  Weekday  Saturday

Have you had a serious illness, injury or surgery?  Yes  No If yes, please describe:

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**TO BE COMPLETED BY PHYSICIAN OR NURSE PRACTITIONER**

1. Current complaints/disabilities pertinent to the student's participation in training program.

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2. Medication used: Prescription and over-the-counter (use back if necessary)

**Name**

**Indication**

**Frequency**

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3. Significant medical history, accidents, deformities, surgeries, back problems, communicable diseases:

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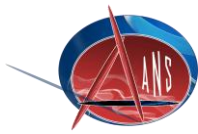
4. Examination Comments and findings:

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICAL EXAM**

**NORMAL**

**COMMENTS**

Yes No

PHYSICAL EXAM	Yes	No	COMMENTS
<b>Urethral Discharge</b>			_____
<b>Rectum, Prostate, Occult Blood</b>			_____
(Optional as indicated by history)			_____
<b>Spine</b>			_____
Inspection			_____
Flexion			_____
Extension			_____
Side Bend			_____
Rotation			_____
Palpation			_____
<b>Shoulders</b>			_____
Overhead Extension			_____
Abduction			_____
Palpation			_____
Deformity			_____
<b>Elbows/Wrists</b>			_____
Motion			_____
Palpation			_____
Deformity			_____
<b>Hands/Fingers</b>			_____
Grasp			_____
Deformity			_____
<b>Lower Extremities</b>			_____
Feet			_____
Ankles			_____
Knees			_____
Hips			_____
General			_____
<b>Neurological</b>			_____
DTS's			_____
Romberg			_____
Focal Weakness			_____
Focal Sensory Defect			_____

Please comment on all abnormal findings:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Evaluator: \_\_\_\_\_

Medical Evaluator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_