Physical Examination

Southern Illinois University Edwardsville Health Service

Last Name ______ First Name ______ Middle Initial ______

ID Number ______ Date of Birth (MO/DAY/YR) ______

	Normal	Abnormal	Comments
Skin			
Ears			
Eyes			
Nose			
Throat			
Mouth / Dental			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Neurological			
Musculoskeletal			
Spinal examination			
Nutritional status			
Other			

Height ________ Weight ________ BMI ________ Vision (R) ________(L) ________

Blood Pressure ________ Pulse ________ Respiration ________ Temperature ________

Immunization History (Mo/Day/Yr)

	# 1	# 2		# 1	# 2	# 3
Rubeola	______	______	DPT	______	______	______
Rubella	______	______	Td Booster	______	______	______
Mumps	______	______	Hepatitis B	______	______	______
Varicella	______	______				

Disease by Date: ______

Titers: (School of Nursing & School of Pharmacy Requirement)

Rubella titer (send copy lab report) ______ Varicella titer (send copy lab report)______

Other titers (send copy lab reports)

PPD (Mantoux required) Tuberculin skin test: #1 Date ______ Result ______

OR send Chest x-ray report #2 Date ______ Result ______

Physical Limitations: ☐No ☐Yes Explain ______

______
Provider Signature

______
Date

______
Print name

(____)______
Telephone

______
Address

______