



**\*Physical Exam must be completed annually. Both pages must be uploaded to the tracker.**

**Physical Exam**

**Part I: Personal Data/Medical History.** To be completed by the student.

**Patient Full Name** \_\_\_\_\_

Sex M \_\_\_ F \_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ GSW ID# \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

E-mail addresses \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Relationship to patient: \_\_\_ Parent \_\_\_ Guardian \_\_\_ Spouse \_\_\_ Other

**MEDICAL HISTORY**

List medication to which you are allergic and give dates and descriptions of reactions. (If “none” please indicate.)

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

List and give dates (by occurrence or onset) of any major illnesses or hospitalizations you have had. (If “none” please indicate.)

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

List and give dates of significant injuries or surgery. (If “none” please indicate)

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

List medication you are taking. (Include oral contraceptives, allergy injections, herbals, etc. If “none” please indicate.)

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

Do you have any physical or mental challenges or conditions\* that may impact your activity? Yes \_\_\_ No \_\_\_

\*See the Essential Technical Standards in the Student Handbook. All nursing students must demonstrate the ability to meet the Essential Technical Standards with reasonable accommodation upon admission and throughout the nursing program.

*To the best of my knowledge, all medical history statements are true with no abnormality, limitations, or restrictions not mentioned in this record. The School of Nursing will be notified of changes in physical or mental health prior to registration and throughout my enrollment in the nursing program.*

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Student Name \_\_\_\_\_

GSW ID \_\_\_\_\_

**Part II.** To be completed by physician or certified nurse practitioner and returned prior to beginning the nursing program. Back of form may be used for additional comments when necessary.

1. Vision normal with correction ( ) without glasses ( ) Color vision defective? No ( ) Yes ( )
2. Hearing normal? No ( ) Yes ( )
3. Blood Pressure\_\_\_\_\_ Within normal limits? No ( ) Yes ( )
4. Height\_\_\_\_\_ inches Weight\_\_\_\_\_ pounds BMI\_\_\_\_\_
5. Physical Examination Comment on abnormalities on back of form

System	Normal	Abnormal	System	Normal	Abnormal
Skin			Abdomen		
Head, Face, Neck			Endocrine System		
Nose & Sinuses			Spine		
Mouth & Throat			Neurological		
Teeth			Genitalia		
Lungs & Chest			Breasts		
Heart			Pelvic if indicated		
Vascular System			Hernia		
Mental Status					

9. Are there any known mental or physical health problems that would affect progress in the nursing program or participation in clinical nursing activities?  
No ( ) Yes ( ) If yes, please specify on back of form
10. Are there allergies that could be exacerbated by clinical environment or activities?  
No ( ) Yes ( )

**TO MY KNOWLEDGE, THE INFORMATION I HAVE SUPPLIED ON THIS HEALTH FORM IS ACCURATE AND COMPLETE**

\_\_\_\_\_  
Signature of Physician or Certified Registered Nurse Practitioner \_\_\_\_\_ Date

Please print or type provider's name \_\_\_\_\_

Medical Office Address Sticker or Stamp Required \_\_\_\_\_