

Clark University Health Services

UNDERGRADUATE PHYSICAL EXAMINATION FORM

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Name: \_\_\_\_\_ Sex at birth: \_\_\_\_ Gender: \_\_\_\_ Pronouns: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does the student have any past/current medical problems?  Yes  No If yes, please describe: \_\_\_\_\_

Does the student have a history of past/current emotional or psychological problems?  Yes  No

If yes, please describe: \_\_\_\_\_

Has the student 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/\_\_\_\_

TB Risk: Low  High  *If risk is high, patient must complete a PPD or QuantiFERON Gold or T-SPOT*

PPD Result: \_\_\_\_mm induration QuantiFERON-TB Gold or T-SPOT Result \_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Attach Lab Report)

Date of Exam ____/____/____	Normal	Abnormal Findings
Appearance		
Skin		
HEENT		
Lymph Nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary		
Musculoskeletal		
Neurological		
Psychological		

The student  should  should not have additional  medical  psychological follow up.

Explain treatment plan for additional follow up: \_\_\_\_\_

**Healthcare provider:**

- Contact Health Services at 508-793-7467 to discuss availability of services if medical follow up recommended.

- Contact The Center for Counseling and Personal Growth at 508-793-7678 if psychological follow up recommended.

Healthcare provider (Print): \_\_\_\_\_ NP/PA/MD/DO

Address \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Signature of Healthcare provider: \_\_\_\_\_ Date: \_\_\_\_\_