

Keene State College Center for Health and Wellness

Physical Examination Form

This form must be completed by a physician, APRN or a PA. Please complete the Physical Examination below. Please comment on all pertinent findings and be sure all information is complete.

Name _____ Sex M ___ F ___ T ___ Date of Birth _____

Blood Pressure _____ Pulse _____ Weight _____ Height _____ BMI _____

Visual Activity: OD 20/ _____ OS 20/ _____ Corrective Lenses (with / without) _____

History	Exam – “WNL” or note abnormalities			
<table style="width: 100%; border: none;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center; width: 10%;">YES</td> <td style="text-align: center; width: 10%;">NO</td> </tr> </table>		YES	NO	
	YES	NO		
1. Allergies (food, medicine, other) <input type="checkbox"/> <input type="checkbox"/>	Psychological _____			
2. Concussion(s) <input type="checkbox"/> <input type="checkbox"/>	Derm _____			
3. Orthopedic Injury <input type="checkbox"/> <input type="checkbox"/>	HEENT _____			
4. Prior exertional chest pain <input type="checkbox"/> <input type="checkbox"/>	Neck/Thyroid _____			
5. Excessive, unexplained shortness of breath or fatigue with exercise <input type="checkbox"/> <input type="checkbox"/>	Respiratory _____			
6. Prior history of heart murmur Or increased blood pressure <input type="checkbox"/> <input type="checkbox"/>	Cardiac _____			
7. Prior exertional syncope or near syncope <input type="checkbox"/> <input type="checkbox"/>	Gastro/Intestinal _____			
8. Family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50 <input type="checkbox"/> <input type="checkbox"/>	Extremities _____			
<p>If you answered “yes” to any of the history points above, please explain</p> <hr/> <hr/> <hr/>	Neurological _____			
	Genitals/Hernia _____			
	<hr/>			
	Laboratory (if indicated)			
	HGB/HCT: _____			
	URINE (DIP): _____			

Pertinent Past Medical/Psychological History _____

Current Medications _____ Sports Restrictions _____

MD/APRN/PA _____ Date _____

Address _____ Phone _____

Signature _____ Fax _____