Xavier University of Louisiana

PHYSICAL EXAMINATION FORM

(please print or type)

Name ________________________________ ID# ___________________________ Birth Date _____________

Male __ Female __ Allergies __________________________________ Height ________ Weight ________

BMI _______ BP ______ /______ Pulse ________ Respiration ____________ Temp ___________

Vision R 20/ _______ L 20/ _______ Corrected: Y N Pupils: Equal _____ Unequal _____

****Visual acuity equal or better than 20/30 for each eye is required to pass visual acuity mandate.**

	Normal	Abnormal Findings	Initials
Medical			
Eyes/Ears/Nose/Throat **Hearing Test (optional)**			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Musculoskeletal			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand/Fingers			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot/Toes			

Clearance

- □ Cleared
- □ Cleared after completing evaluation/rehabilitation for:

- □ Not cleared for: ______________________________ Reason: ___________________________________

  Recommendations:

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I certify that I have reviewed the health history and examined this person and find no contraindications for participation in _______________________________. (Note exceptions above)

Examiner (please print): ____

Examiner's Signature: ____ Date: _________________

Examiner's Phone Number: ___________________________Email: ______________________________

Note: Consent and HIPAA Release Forms must be signed by the student on a separate sheet.
History and Physical Examination Forms are modified from the forms approved by the American Academy of Family Physicians, the American Academy of Pediatrics, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine and the American Osteopathic Academy of Sports Medicine.

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PHYSICAL EXAMINATION FORM

(please print or type)

Name ___________________________________ ID# ________________________ Birth Date ________________

Personal History

Have you ever had any of the following? If yes, give details and dates.

	YES	NO	
Allergies, food, drugs, other			
Anemia or other blood diseases			
Arthritis			
Asthma			
Diabetes			
Fainting Spells			
Meningitis			
Nervous or Mental Disease			
Pilonidal Disease			
Pneumonia			
Poliomyelitis			
Rheumatic Fever			
Hernia			
Hospitalizations			
Hypertension			
Ear Disease , Mastoid, Etc.			
Epilepsy			
Hay Fever			
Heart Disease			
Liver Disease			
Kidney Disease			
Sinus Disease			
Skin Disease			
Surgery			
Thyroid			
Tuberculosis			
Malaria			
Ulcer: Stomach or Duodenal			
Venereal Disease (STD/STI)			
Vertigo (Dizziness)			

List any medications you are currently taking including birth control, supplements and over the counter:

____

Reviewed: _________
Initials

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