



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: \_\_\_\_\_

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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(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**