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 _____

	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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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