# Physical Examination

## Southern Illinois University Edwardsville Health Service

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____
ID Number SSN Date of Birth (MO/DAY/YR)

| | Normal | Abnormal | Comments |
|---|---|---|---|
| Skin | | | |
| Ears | | | |
| Eyes | | | |
| Nose | | | |
| Throat | | | |
| Mouth / Dental | | | |
| Cardiovascular | | | |
| Respiratory | | | |
| Gastrointestinal | | | |
| Genito-Urinary | | | |
| Neurological | | | |
| Musculoskeletal | | | |
| Spinal examination | | | |
| Nutritional status | | | |
| Other | | | |

Height _____ Weight _____ BMI _____ Vision (R) _____(L)_____

Blood Pressure _____ Pulse _____ Respiration _____ Temperature _____

Urine: Specific Gravity _____ Sugar _____ Albumin _____ Micro _____

**Immunization History** (Mo/Day/Yr)

| | # 1 | # 2 | | # 1 | # 2 | # 3 |
|---|---|---|---|---|---|---|
| Rubeola | _____ | _____ | DPT | _____ | _____ | _____ |
| Rubella | _____ | _____ | Td Booster | _____ | _____ | _____ |
| Mumps | _____ | _____ | Hepatitis B | _____ | _____ | _____ |
| Varicella | _____ | _____ | | | | |

Disease by Date: _____

Titers: (School of Nursing & School of Pharmacy Requirement)

Rubella titer (send copy lab report) _____ Varicella titer (send copy lab report)_____

Other titers (send copy lab reports)

PPD (Mantoux required) Tuberculin skin test: #1 Date _____ Result _____

OR send Chest x-ray report #2 Date _____ Result _____

**Physical Limitations**: ☐No ☐Yes Explain _____

_____ _____
Provider Signature Date

_____ (_____)_____
Print name Telephone

_____
Address

_____