Samford University
College of Health Sciences

PHYSICAL EXAMINATION

Program of Study _____

SUID # _____

_____ **SEX:** M ____ F ____

LAST NAME **FIRST NAME** **MIDDLE** **BIRTH DATE**

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. Vision _____right _____left

The College of Health Sciences (CHS) requires that all students have evidence of a physical examination from a physician, physician's assistant, or nurse practitioner verifying that the individual is able to meet physical and mental requirements – with or without accommodation – for both didactic and clinical components of their respective program. The physical examination must be completed and this form submitted before the first day of class and annually thereafter. The student affirms that by submitting this form he or she consents to the disclosure of the information contained herein to the program, school and college's administrators, faculty and staff, as well as experiential site preceptors/coordinators as is necessary to ensure compliance with program requirements and affiliated site requirements.

REVIEW OF SYSTEMS:
Are there abnormalities in the following systems? Describe fully, including any assistive devices which may be required (e.g. hearing aids, eyeglasses, prosthetics, etc.).

	NO	YES	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Musculoskeletal			
Neurologic			
Dermatologic			

ALLERGIES: _____

Is the patient now under treatment for any medical or psychological condition? NO_____ YES _____ (explain) _____

Does this patient have any active prescriptions, even if for occasional use only? NO_____ YES _____ (list) _____

Has this patient ever been diagnosed with alcoholism or another drug dependency (not including tobacco)? NO _____ YES _____ (list) _____

Are there any conditions, physical and /or psychological, which may interfere with functioning as a health professional student in the classroom or clinical setting? NO _____ YES _____ (please comment)

NOTES/COMMENTS:_____

Healthcare Professional's Name/Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE OF PROVIDER:_____ DATE:_____

***Veterans: Your Discharge Physical is Acceptable**