# PHYSICAL EXAMINATION

Must be completed within twelve months of enrollment or you may attach a signed copy of your most recent physical examination.

**Student Name** ________________________ **Date of Exam** ________________

Height _________ Weight _________BP ___________Pulse __________ Hearing: Right _________Left ____________

Vision: Without correction: Right 20/______Left 20/______ With correction: Right 20/_______Left 20/_________

| SYSTEM | NORMAL | DESCRIBE ABNORMALITY |
|---|---|---|
| Skin | | |
| HEENT | | |
| Respiratory | | |
| Breast | | |
| Cardiovascular | | |
| Gastrointestinal | | |
| Genitourinary | | |
| Lymphatic | | |
| Musculoskeletal | | |
| Neurological | | |
| Endocrine | | |
| Psychological | | |
| | | |

Lab Work (if indicated): Hgb/Hct:______Cholesterol: _______ Urine: Glucose: ______Protein:________Micro: _______

**CURRENT MAJOR & CHRONIC PROBLEMS**

______________________________

______________________________

______________________________

**ACUTE & MINOR PROBLEMS**

______________________________

______________________________

______________________________

*If the student is under care for a chronic condition or serious illness please provide additional clinical reports to assist us in providing continuity of care.*

Additional comments and recommendations:________________________________

________________________________

Please list any special **DIETARY REQUIREMENTS:** ________________________

Please list all **ALLERGIES** (including medications, insect venom, foods, etc): ________________________

Type of reaction ________________________

Please list all **MEDICATIONS** currently being taken (include OTC's, contraceptives): ________________________

________________________

Recommendations for physical activity: ☐ unlimited ☐ limited (specify) ________________________

Medical Provider (please print)________________________

Address________________________

Phone ( ___)____________________ Fax ( ___)____________________

Provider's Signature________________________

**Mail completed form to:**
**UMASS Lowell**
**Wellness Center**
**Health Services**
**220 Pawtucket Street, Suite 300**
**Lowell, MA 01854-5144**
**Telephone: (978) 934-6800**