EMORY

School of Medicine
School of Medicine – Allied Health
School of Nursing
Student Health Services

PHYSICAL EXAMINATION FORM

Allied Health, Medical and Nursing Students

This is a confidential form that must be filled out by the student and his/her primary care clinical provider. The student will not be fully registered and enrolled until BOTH the front and back of this form are completed, signed, and returned to Emory University Student Health Services. Please upload this **completed and signed form** via 'Your Patient Portal' as directed on the 'IMMUNIZATIONS' page of the Portal. Nursing students will also need to send a copy to the School of Nursing in addition to the Student Health Services. If you are unable to upload your documents, we will accept submissions by email, US mail, or fax:

To email a PDF scanned version of this completed document: Use your EMORY.EDU email address and send to: Immunizations-SHS@emory.edu.

To send by US mail or fax, please see instructions below. Nursing students send to both School of Nursing AND Student Health.

Allied Health and Medical Students

Emory Student Health Services
Attention: Immunization Nurse
1525 Clifton Road NE
Atlanta, GA 30322
Fax: 404-727-5349

Nursing Students

Emory University School of Nursing
Attention: Nicole Ingram
1520 Clifton Road NE
Atlanta, GA 30322

AND

Emory Student Health Services
Attention: Immunization Nurse
1525 Clifton Road NE
Atlanta, GA 30322
Fax: 404-727-5349

Student's Name:_____ Emory ID#: _____

Street Address:_____

City:_____ State:_____ ZIP:_____ Country:_____

Gender: ❒ Male ❒ Female ❒ Transgender (please elaborate): _____

Date of Birth (mm/dd/yyyy): _____/_____/_____

❒ Medical Student ❒ Allied Health Student (Program:_____) ❒ Nursing Student

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	❒	❒	Epilepsy/Seizures	❒	❒	Positive PPD Test/Tuberculosis	❒	❒
Cancer	❒	❒	Gastrointestinal Disorder	❒	❒	Psychiatric/Behavior Disorder	❒	❒
Cardiovascular Disease	❒	❒	Hepatitis/Jaundice	❒	❒	Pulmonary/Lung Disease	❒	❒
Diabetes	❒	❒	High Blood Pressure	❒	❒	Skin Problems/Disease	❒	❒
Drug/Alcohol Abuse	❒	❒	Kidney/Urinary Disorder	❒	❒	Tobacco use (current or past)	❒	❒
Endocrine Disorder	❒	❒	Musculoskeletal Disorder	❒	❒	Other:_____		❒
						Other:_____		❒

Comments (please explain any YES answers above): _____

_____

List all allergies: _____

_____

Surgeries (with dates):_____

_____

Previous hospitalizations (with dates):_____

_____

Current medications: _____

_____

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature:_____ Date:_____

PHYSICAL EXAMINATION

(This page must be completed and signed by your physician, nurse practitioner or physician assistant.)

Patient's Name: _____

Height:_____ Weight:_____ Temp:_____ BP:_____ Pulse:_____ RR:_____

Vision: OD_____ OS_____ OU_____ Without correction:_____

OD_____ OS_____ OU_____ With correction:_____

	Normal	Abnormal	Comments
HEENT	❒	❒	_____
Neck	❒	❒	_____
Lungs	❒	❒	_____
Heart	❒	❒	_____
Abdomen	❒	❒	_____
GU (if indicated)	❒	❒	_____
Extremities	❒	❒	_____
Neurologic	❒	❒	_____
Adenopathy	❒	❒	_____
Vascular	❒	❒	_____
Skin	❒	❒	_____
Psychiatric	❒	❒	_____

How long and on what basis have you known this patient?

Months:_____ Years:_____ ❒ This visit only

❒ Professional basis ❒ Personal basis

To your knowledge, does this patient have any significant medical problems? ❒ Yes ❒ No

Explain:_____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems? ❒ Yes ❒ No

Explain:_____

Do you know of any physical or psychological reason why this student would not be able to withstand the rigors of medical school education? ❒ Yes ❒ No

Explain:_____

Labs (if indicated): CXR_____ U/A_____

CBC or H/H_____ Pap_____

Other_____ Other_____

Physician/NP/PA Name:_____ Phone: (_____) _____

Address:_____

Physician/NP/PA Signature:_____ Date: _____

Revised 6/2017