Physical Examination Record

First Name _____ Middle Name _____ Last Name _____

Date of Birth: _____ M#: _____

This information will remain as part of the secured student file in Health Services Office and will remain confidential at all times. The MSM-PA program requires an annual updated medical history, immunizations and physical examination and the immediate notification to the Office of Student Affairs if any health status issues change in the interim. **Please upload form into Ace-Mapp and send all immunizations questions to Employee Health and Wellness Center at shwcrequests@msm.edu**

Student signature: _____

To be completed and signed by healthcare provider

Print Name: _____ _____ _____
First Middle Last

Height (Inches): _____ Weight (Pounds): _____ BP: _____ / _____ Pulse: _____

Vision: Right 20/_____ Left 20/ _____

Enter "NE" if not evaluated

Medical	Normal	Abnormal	Give details of each abnormality
Head, Neck, Face and Scalp			
Nose and Sinuses			
Mouth, Teeth, Gingiva and throat			
Ears-General (canals, drums, etc.)			
Eyes-General (lids, pupils, motions etc.)			
Lungs, chest, and breasts			
Heart (include estimate of cardiac function)			
Vascular system (include varicosities)			
Abdomen and Vicera (include hernia)			
Anorectal and Pilonidal			

Continued on next page

Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic? No Yes

If yes, please describe: _____

_____

_____

_____

Any allergies to medications? No Yes

If yes, please describe: _____

_____

_____

_____

Healthcare Provider Office Only

Healthcare Provider's Name:EMC BT /45 0 WTj Q4 2 (thc)3.9 ( )]TJ 0 Tc 0 Tw >>BD3car >BD3car >BD3 3.78-6.