PHYSICAL EXAM FORM FOR
UTEP SCHOOL OF NURSING

NAME (Please print):	**PROGRAM:**	**DOB:**

FAMILY HISTORY: please give a general medical history (enter N/A if not applicable)

PERSONAL HISTORY: please answer ALL questions. *Comment below on ALL positive answers below***.**

Have you had:	**YES**	**NO**	**Have you had:**	**YES**	**NO**
INFECTIOUS DISEASES			CARDIOPULMONARY		
Measles			Shortness of breath		
German Measles			Palpitations		
Mumps			Chest pains/pressure		
Chicken Pox			Chronic cough		
Malaria			High blood pressure		
Tuberculosis			Rheumatic fever		
Mononucleosis			Heart murmur		
Hepatitis			Recurrent colds		
Sexually Transmitted			Other *(Comment Below)*		
Other *(Comment Below)*					
DENTAL DISORDERS			MUSCULOSKELETAL		
Gum or Dental problems			Disease or injury of joints		
Sinusitis			Arthritis		
Eye problems			"trick" knee/shoulder, etc.		
Ear problems			Back problems		
Throat problems			Other *(Comment Below)*		
IMMUNOLOGICAL			ENDOCRINE/METABOLIC		
Hay fever			Diabetes		
Asthma			Thyroid problems		
Allergies *(Comment Below)*			Other *(Comment Below)*		
GASTROINTESTINAL & GENITOURINARY			NEUROLOGICAL DISORDERS		
Frequent nausea			Frequent headaches		
Frequent diarrhea			Dizziness or vertigo		
Constipation			Head injury		
Frequency of urination			Epilepsy		
Burning on urination			Fainting		
Gall bladder problems			Weakness		
Other *(Comment Below)*			Paralysis		
			Convulsions		
BLOOD DISORDERS			MISCELLANEOUS		
Clotting disorder			Tumors		
Hemophilia			Cancer		
Leukemia			Cysts		
Anemia (type)			Other *(Comment Below)*		
PSYCHOLOGICAL			FEMALES ONLY		
Insomnia			Irregular periods/excess		
Anxiety			Severe cramps		
Depression			Pregnant?		
Other *(Comment Below)*			Other *(Comment Below)*		

COMMENTS:

List ALL medications you take regularly *(enter N/A if not applicable)***:**

List any Surgeries *(enter N/A if not applicable)***:**

Please answer all questions. Comment below on ALL positive answers below.	YES	NO
A. Has your physical activity been restricted during the past 5 years?		
Comment:		
B. Have you had difficulty with school studies or teachers?		
Comment:		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, emotional problems or chemical/alcohol dependence?		
Comment:		
D. Have you had an illness or injury or been hospitalized other than that already noted?		
Comment:		
E. Have you consulted or been treated by clinics, doctors, healers or other practitioners within the past 5 years?		
Comment:		
F. Have you been rejected or discharged from military service or employment because of physical, emotional or other reasons?		
Comment:		
G. Do you have any learning or physical disabilities for which you may require assistance?		
Comment:		

ADDITIONAL INFORMATION *(enter N/A if not applicable)*:

Height	Weight	BP	P	R	Corrected Vision R	L

Are there any abnormalities in the following systems:

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Head, Ears, Nose, or Throat				
Respiratory				
Cardiovascular/Blood				
Gastrointestinal				
Hernia				
Eyes				
Genitourinary				
Musculoskeletal				
Metabolic/Endocrine				
Neurological				
Skin				
Psychiatric/Emotional				

Healthcare Provider Recommendations (comment on ALL positive answers below):	Yes	No
Recommendations for accommodations for any physical activity (including lifting, carrying, standing)		
Comment:		
Recommendations for accommodations for any learning or emotional disabilities		
Comment:		

General Comments *(enter N/A if not applicable)*:

EXAMINER'S SIGNATURE (Note: Doctor or Advanced Nurse Practitioner must be licensed to practice in the United States)

____ Date: __________________

____ ____

Examiners name and title (typed or printed) Address