The University of Findlay
College of Sciences
Health Sciences Programs

HEALTH FORM / PHYSICAN'S EXAMINATION

PART ONE: TO BE COMPLETED BY THE STUDENT PRIOR TO THE EXAM

General Information:

Name:_____ Gender:_____ Birth date:_____

Address:_____ Phone_____

City:_____ State:_____ Zip:_____

UF ID#_____ Today's Date:_____

Health Professions Program: _____

History:

Do you have, or have you had any of the following illnesses or conditions?

Asthma	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	TB	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Other serious illness or condition currently	Yes ☐	No ☐			

Details of any "Yes" answers from above:

_____

_____

_____

_____

Previous Injuries: _____

Previous Surgeries:_____

Allergies: _____

Current Medications: _____

_____

_____

PART TWO: TO BE COMPLETED BY THE PHYSICIAN

Physical Examination:

Vital Signs: Ht: _____ (inches) Wt:_____ (lbs.) BP_____/_____ Pulse _____

	Normal	Abnormal	Comments
General Appearance			
HEENT			
Lungs			
Heart			
Abdomen			
Back			
Extremities			
Neurologic			

Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic?

☐ Yes ☐ No If yes, please describe on a separate sheet.

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____

Appendix I

Consent:

I direct that a copy of this exam form, including laboratory results, be sent to my assigned clinical centers and coordinators.

Student Signature: _____ Date: _____

Practitioner Contact:

If you are currently in treatment for any condition, physical or emotional, may we contact your practitioner in an emergency? Yes ☐ No ☐

Student Signature: _____ Date: _____

If yes, please provide us with the following information:

Practitioner's Name: _____ Specialty: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____