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 Pelvic		
(if indicated)		
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