

University of St. Thomas

Part II—Physical Examination

Student Health Service
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Name (Last, First, MI)	Birthdate:	UST ID
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MEDICAL EXAMINATION:

ROS: _____	BP: _____	Height (inches): _____
_____	R: _____	Weight: _____
_____	P: _____	BMI: _____
_____	T: _____	

	NL	ABNL		NL	ABNL		NL	ABNL
PE:			Abdomen:			Psychiatric		
General:			Organs	<input type="checkbox"/>	<input type="checkbox"/>	Oriented	<input type="checkbox"/>	<input type="checkbox"/>
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Affect	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic Female (optional):			Mood	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Pap done	<input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Affect	<input type="checkbox"/>	<input type="checkbox"/>
HEENT:			Vagina	<input type="checkbox"/>	<input type="checkbox"/>	Judgment	<input type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cervix	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Uterus	<input type="checkbox"/>	<input type="checkbox"/>			
PERRLA	<input type="checkbox"/>	<input type="checkbox"/>	Adnexae	<input type="checkbox"/>	<input type="checkbox"/>	Please Explain ABNL: _____		
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	Males:			_____		
Ears/TM	<input type="checkbox"/>	<input type="checkbox"/>	Testicular exam	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Rectal	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Mouth/Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal Screen:			_____		
Neck:			Neck	<input type="checkbox"/>	<input type="checkbox"/>	Vision Left _____ Right _____		
Bruits	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Corrected / Uncorrected: _____		
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	General: <input type="checkbox"/> Well-groomed <input type="checkbox"/> Disheveled		
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Chest:			Back	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Lung auscultation	<input type="checkbox"/>	<input type="checkbox"/>	Quad/ham	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Breasts (optional):			Ankle	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Palpation	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	Heel/toe	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heart:			Duck walk	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Neuro:	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	CN2-12	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Pulses	<input type="checkbox"/>	<input type="checkbox"/>	DTRs	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Lymphatics:			Sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cervical	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Axilla	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Groin	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Other	<input type="checkbox"/>	<input type="checkbox"/>				_____		

ASSESSMENT

1. General Health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Other: _____
2. Physical Activity: <input type="checkbox"/> Unrestricted <input type="checkbox"/> Restricted	_____
3. May participate in NCAA sports, club sports, intramurals, PE) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

PLAN

Examiner's comments/other recommendations: <input type="checkbox"/> Reviewed health lifestyle/encouraged application. _____ _____ _____	LAB (optional): Hgb: _____ UA: _____
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Date of Physical Examination _____/_____/_____				
Health Care Provider (Please Print)	Health Care Provider Signature			
Address	City	State	Zip Code	Phone ()