

### Physical Examination

Physician. Please review the student's history and complete the physician's form. Please comment on all positive answers. *This student has already been accepted to the Univ. of Saint Mary.* The information supplied will not affect his/her status; it will be used only as a background for providing helath care, if necessary. This information is strictly confidential, for use by the Health Services, and will not be released without student consent.

Sex: Male  Female

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

HEALTH CATEGORIES	Normal	Abnormal	Comment
Anal-Hemorrhoids			
Pilonidal Cyst			
Other			
Abdomen-Scars			
Tenderness			
Masses			
Liver			
Spleen			
Kidneys			
Chest-Inspection			
Pulmonary findings			
Breasts			
Axillary Nodes			
Ears-Hearing			
Canals			
Drums			
Emotional Stability			
Evidence of Psychiatric Disorders			
Extremities-Reflexes			
Anatomy & Movement			
Arms			
Hands			
Legs			
Feet			
Eyes-Distant Vision     R			
(Snellen Chart)     L			
Corrected            R			
L			
Pupils               R&L			
Lids			
E.O. Muscles			
Color Vision			

	Normal	Abnormal	Comment
Genitalia-Hernias			
Pelvic			
Scrotum/Testes			
Other			
Heart-Size			
Rhythm			
Thrills			
Murmurs			
Blood Pressure			
Neck-Thyroid			
Lymphatic Glands			
Other			
Nervous Condition-Tics			
Tremor			
Speech			
Motor Paralysis			
Nose-Throat-Gums			
Dental Repair			
Pharynx			
Other			
Orthopedics			
Posture			
Spine			
Skin Condition			
Nails			
Hair			

Urinalysis  Albumin  Sugar  Blood  Hematocrit   
 Other Findings (Pertinent laboratory reports) \_\_\_\_\_

Is there loss or seriously impaired function of any paired organ?     Yes      No   
 Recommendations for physical activity (PE, intramurals)     Unlimited      Limited   
 For those participating in intercollegiate Athletics, please note participation limitation:     Unlimited      Limited      Postponed   
 Do you have any recommendations regarding the care of this student?     Yes      No   
 Is the patient now under treatment for any medical or emotional condition?     Yes      No   
 Are there any other disabilities?     Yes      No

**For all positive or limited responses, please explain on the back of this form.**

Physician's Name (please print) \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone \_\_\_\_\_ Date \_\_\_\_\_  
 Physician's Signature \_\_\_\_\_

**Return all health information to:**  
 Coordinator of Health Services  
 University of Saint Mary  
 4100 S. 4<sup>th</sup> Street Trafficway  
 Leavenworth, KS 66048-6500