Thomas COLLEGE Health Center

PHYSICAL EXAMINATION

TO BE COMPLETED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT, OR NURSE PRACTITIONER. TO AVOID DELAY IN THIS STUDENT'S MATRICULATION, PLEASE GIVE AS COMPLETE AND DETAILED INFORMATION AS POSSIBLE. PLEASE LEAVE NO BLANK SPACES. THE WORD "NORMAL" WRITTEN ACROSS THE PAGE AND A LINE DRAWN THROUGH A SPACE OR MULTIPLE SPACES IS NOT ACCEPTABLE. The physical examination must be within one year prior to entrance date. Give your health care provider a stamped envelope addressed to: Health Center, Thomas College, 180 W. River Rd., Waterville, ME 04901. This can also be faxed to (207)859-1126 or emailed to healthctr@thomas.edu.

Name: _____ Sex: M_F_____ DOB: _____

Date Form Completed:_____(*Month*, *Day*, *Year*)

Height_____inches Weight_____lbs. BP _____ Pulse _____ Vision R 20/_____L 20/ _____

HEAD/SCALP: _____ EYES (Pupils, EOM's, Fundi): _____

NOSE/THROAT: _____ TONSILS: Present_____Removed _____

EARS: _____ HEARING: R_____L _____

LUNGS: _____ NECK:_____THYROID: _____

CHEST: _____ HEART: _____

ABDOMEN: _____ SPINE: _____

EXTREMITIES: _____ NEUROLOGICAL: _____

JOINTS/MOBILITY: _____

Are there any conditions of which we should be aware? Please describe fully. Use additional sheet if necessary. _____

_____

Is there loss or impairment of any paired organ? _No _Yes (explain)_____

_____

Is this student now under treatment for any medical or emotional condition? _No _Yes (explain)_____

_____

Name, address, phone number of mental health professional (if applicable)_____

Is the student currently taking any medications? _No _Yes Please list, indicating purpose, dose, and instructions._____

_____

Is any follow-up by the college Health Center staff indicated? _____

Comments:_____

Recommendations for physical activity (intramural, etc.) _Unlimited __Limited Define activities allowed or not allowed.

_____

Examiner's Signature _____ Date of exam_____

Print Last Name _____ Phone #_____
(include area code)

Address_____
Street City State Zip Country