EMORY UNIVERSITY | Student Health Services
Campus Life

PHYSICAL EXAMINATION FORM

Allied Health, Medical and Nursing Students Only

All incoming medical, nursing, and allied health students must return this completed, signed form **PRIOR TO MATRICULATION** through one of the following methods:

- Upload the form to your Student Patient Portal (***preferred***), **or**
- Email a PDF to immunizations-shs@emory.edu, **or**
- Fax to: 404-727-7343, **or**
- Mail to: **Emory University Student Health Services**
  Attention: Immunization Department
  1525 Clifton Road NE, Atlanta, GA 30322

Student's Name:_____ Emory ID#: _____

Street Address:_____

City:_____State: _____ ZIP:_____ Country:_____

Gender: ❒ Male ❒ Female ❒ Transgender: MTF_____ FTM_____ Other_____

Date of Birth (mm/dd/yyyy): ____/____/_____

Please select your degree program *(Circle One)*: AA DPT Genetic Couns Med Imaging MD Nursing PA

Do you now have or have you ever had:

	No	Yes		No	Yes		No	Yes
Allergies/Asthma	❒	❒	Epilepsy/Seizures	❒	❒	Positive PPD Test/Tuberculosis	❒	❒
Cancer	❒	❒	Gastrointestinal Disorder	❒	❒	Psychiatric/Behavior Disorder	❒	❒
Cardiovascular Disease	❒	❒	Hepatitis/Jaundice	❒	❒	Pulmonary/Lung Disease	❒	❒
Diabetes	❒	❒	High Blood Pressure	❒	❒	Skin Problems/Disease	❒	❒
Drug/Alcohol Use	❒	❒	Kidney/Urinary Disorder	❒	❒	Tobacco/Vaping use (current or past)	❒	❒
Endocrine Disorder	❒	❒	Musculoskeletal Disorder	❒	❒	Eating Disorder	❒	❒

Other illnesses/Comments (please explain any YES answers from above): _____

_____

Allergies: Yes or No. If yes, list all allergies: _____

_____

Surgeries (with dates):_____

_____

Previous hospitalizations (with dates):_____

_____

Current medications: _____

_____

I attest that the information shown above is true and accurate to the best of my knowledge.

Student's Signature:_____ Date:_____

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PHYSICAL EXAMINATION

This page must be completed, signed, and stamped by a non-relative provider, nurse practitioner or physician assistant.

Patient's Name: _____ Emory ID#: _____Date of Exam: _____

Height:_____ Weight:_____ BMI:_____ Temp:_____ BP:____/____ Pulse:_____ RR:_____

Vision: OD_____ OS_____ OU_____ Without correction: _____

OD_____ OS_____ OU_____ With correction: _____

	Normal	Abnormal	Comments
HEENT	❒	❒	_____
Neck	❒	❒	_____
Lungs	❒	❒	_____
Heart	❒	❒	_____
Abdomen	❒	❒	_____
GU	❒	❒	_____
Extremities	❒	❒	_____
Neurologic	❒	❒	_____
Adenopathy	❒	❒	_____
Skin	❒	❒	_____
Psychiatric	❒	❒	_____

How long and on what basis have you known this patient?

Months:____Years:____ ❒ This visit only ❒ Professional basis

To your knowledge, does this patient have any significant medical problems? ❒ Yes ❒ No

Explain: _____

To your knowledge, does this patient have any emotional, psychological or psychiatric problems?

❒ Yes ❒ No Explain: _____

Do you know of any physical or psychological reason why this student would not be able to withstand the rigors of his/her program of study? ❒ Yes ❒ No

Explain:_____

Healthcare Provider (MD, DO, NP, PA) Name: _____

Address: _____ Phone: (_____)_____

Healthcare Provider (MD, DO, NP, PA) Signature: _____ Date:_____

Healthcare Provider (MD, DO, NP, PA) Facility Stamp (REQUIRED):