

University of Wisconsin-La Crosse

Physical Therapy Program

STUDENT PHYSICAL FORM

(Must be completed by a physician, nurse practitioner, or physician's assistant who is not a relative)

Name: _____

History

Any significant finding in the student's past health history? Yes No If yes, please specify:

Tobacco use: _____ Alcohol use (drinks/wk): _____ other drug use: _____

Any allergies to medications? Yes No Specify: _____

Any latex or other non-medication allergies? Yes No Specify: _____

Please list current medications and doses, including contraceptives, non-prescription medications, vitamins, and supplements: _____

Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____

| <u>Normal</u> | | <u>Abnormal</u> | <u>Explanation</u> |
|---------------|-------------------------|-----------------|--------------------|
| _____ | Head and Neck | _____ | |
| _____ | Ears and Hearing | _____ | |
| _____ | Nose and Sinuses | _____ | |
| _____ | Mouth and Throat | _____ | |
| _____ | Teeth | _____ | |
| _____ | Eyes and Vision | _____ | |
| _____ | Respiratory and Lungs | _____ | |
| _____ | Heart and Vascular | _____ | |
| _____ | Abdomen | _____ | |
| _____ | Musculoskeletal | _____ | |
| _____ | Metabolic and Endocrine | _____ | |
| _____ | Skin and Lymphatic | _____ | |
| _____ | Neurologic | _____ | |
| _____ | Psychiatric | _____ | |
| _____ | Genitourinary | _____ | |
| _____ | Pelvic (Females) | _____ | |

Additional comments:

Date of Exam: ____/____/____ Clinician Signature _____

Clinician Name Printed: _____

Office Address: _____

Phone # _____

