Franklin Pierce University
Health Services

HEALTH FORMS

Tel (603 899-4130 * Fax (603) 899-1050 * healthservices@franklinpierce.edu

PHYSICAL FORM

Physical Examination to be completed by MD/NP/PA/DO. **DUE: JULY 15**

☐ **MD/NP/PA/DO TO COMPLETE & SIGN THIS PAGE**

To the examiner: Please complete the Physical Examination below and comment on all pertinent findings and be sure all information is complete.

Name:_____ ☐ M ☐ F Date of Birth _____/ _____/ _____

Participating in an intercollegiate sport? ☐ Yes ☐ No If yes, which sport? _____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respirations: _____

Vision: *Without glasses:* Right 20/_____ Left 20/_____ *With glasses:* Right 20/_____ Left 20/_____

Hearing: Right Normal ☐ Yes ☐ No Left Normal ☐ Yes ☐ No Hearing Aid? ☐ Yes ☐ No

Laboratory Tests: HCT _____ HGB _____ Urine _____ Glucose _____ Protein _____

List all current medications: _____

LIST ALL ALLERGIES TO MEDICATIONS, FOOD, AND OTHER: _____

No.	System	WNL	Abn	Briefly describe abnormality
1.	Skin	☐	☐	_____
2.	Eyes	☐	☐	_____
3.	Ears	☐	☐	_____
4.	Nose, throat	☐	☐	_____
5.	Neck, thyroid	☐	☐	_____
6.	Lymphatics	☐	☐	_____
7.	Chest, Breasts, Lungs	☐	☐	_____
8.	Heart, rate/rhythm/sounds	☐	☐	_____
9.	Abdomen	☐	☐	_____
10.	Genitalia, Rectal	☐	☐	_____
11.	Extremities, back, spine	☐	☐	_____
12.	Neurological	☐	☐	_____
13.	Psychological	☐	☐	_____

The applicant is in ☐ excellent health ☐ good health ☐ poor health. The following abnormalities should be noted: _____

_____

★ **TARGETED TB SKIN TESTING:** ☐ **MED.TO HIGH RISK** (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors). **DATE OF PPD:** _____; Results: _____ mm. ☐ **LOW RISK (no PPD done)**.

REQUIRED

1

PRINT NAME: _____ **MD/NP/PA/DO**

_____

STREET ADDRESS **CITY** **STATE** **ZIP**

Office Phone: ( ) _____ **FAX:** ( ) _____

_____ _____

PROVIDER SIGNATURE **DATE OF EXAM**

Complete and return to Franklin Pierce University, Health Services, 40 University Drive, Rindge, NH 03461 by July 15