

PHYSICAL EXAM

STUDENT HEALTH CENTER

To be completed by a physician, physician assistant, or nurse practitioner no more than six months prior to admission.

1021 Dulaney Valley Rd., Baltimore, MD 21204
Phone: (410)337-6050
Fax: (410)337-6051
Upload completed & signed form to:
<https://goucher.medicatconnect.com>

Date of Exam: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name & Pronouns: _____

Date of Birth: _____ Student ID Number: _____

Sex Assigned at Birth: _____ Gender Identity: _____

Examination Findings (Please describe fully and use additional pages if necessary.)

BP: _____ Pulse: _____ Respirations: _____ Height (in.): _____ Weight (lbs.): _____

	Normal	Abnormal	Please explain any abnormal findings:
General Appearance	_____	_____	_____
Skin	_____	_____	_____
Head	_____	_____	_____
Eyes	_____	_____	_____
Nose/sinuses	_____	_____	_____
Mouth	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Neurological	_____	_____	_____
Musculoskeletal	_____	_____	_____

Additional findings or comments: _____

Clearance for physical activity (intercollegiate athletics, PE, horseback riding, intramurals, etc.):

Full Limited Not Cleared Explain: _____

Is the patient under treatment for any medical or mental health conditions? Yes No
Explain: _____

Is the patient taking any medications? Yes No
Please list: _____

Provider's Signature _____ Date _____

Print Name & Title _____ Phone Number _____

Address _____