

EXAM DATE: _____

REVISED 12/13/19

NEUMANN UNIVERSITY PHYSICAL EXAMINATION FORM

IF PLAYING A SPORT THIS FORM MUST BE SIGNED BY A **MEDICAL DOCTOR**

NOT a Nurse Practitioner, Physician Assistant, etc.

Status: FR SO JR SR Sport (if applicable): _____

Name: _____

Date of birth: _____ Age: _____ Student ID # _____

Cell Phone: _____ Home Phone: _____

Home Address: _____
street

_____ city state zip

******(below is for physician/athletic training staff use only!!)******

PHYSICAL EXAMINATION:

Blood Pressure: _____ / _____ mmHg

Heart Rate: _____ beats/min

Height: _____

Weight: _____ lbs.

	NORMAL	ABNORMAL	COMMENTS
Head			
Ears			
Eyes			
Noses			
Throat			
Neck			
Chest/Lungs			
Heart			
Abdomen			
Hernia			
Neurological			
Skin			

ORTHOPAEDIC EXAM:	R	L	Comments
Ankle			
Knee			
Hip			
Back			
Shoulder			
Elbow			

*****PLEASE ATTACH UPDATED IMMUIZATION RECORDS WITH THIS FORM*****

GENERAL ORTHOPAEDIC COMMENTS:

CLEARED FOR ATHLETIC PARTICIPATION? (PLEASE CIRCLE) YES NO

Physician's Office Official Stamp Here

(Physician's Signature ONLY/Date)

Physician's Office Phone Number: _____

Name: _____

REQUIRED IMMUNIZATIONS

Required Prior to Beginning Classes

Attachments Accepted

	1 st	2 nd	3 rd	4 th	5 th
MMR-Must have 2 injections, both after 1 st birthday and at least 30 days apart					
Tuberculosis testing-required within one year of admission	Placed	Read	Results		
Chest X-ray-if TD test is positive	Normal	Abnormal	Date		
DPT/Tdap/Td-tetanus booster must be within last 10 years					
Hepatitis B-series of 3					
Varicella (chicken pox_-2 doses required					
Date of Disease for Chicken Pox					
Meningitis Vaccine					

Immunizations must be up-to-date!

If dates are not available-Titers must be drawn to show immunities-Please attach results!

Physician's Signature: _____ Date Exam was completed: _____

Physician's Printed Name: _____

Address _____

Phone # _____ Fax # _____

Neumann University

HEALTH RECORD AND QUESTIONNAIRE

Print Clearly with a blue or black pen only

Today's date: _____/_____/_____

University Status: FR SO JR SR

PERSONAL INFORMATION:

Name: _____ Sport(s) if applicable: _____

Student ID #: _____ Age: _____ Date of Birth: _____/_____/_____

Campus Address: _____
 (local address) (box#/street) city state zip

Home Address: _____
 (street) city state zip

Home Phone # _____ Campus/local Phone # _____

Parent/Guardian(s): _____

Family Physician: _____ Phone: _____

Do you, or have you ever had, any of the following? Give year and indicate family history where appropriate.

GENERAL HEALTH	Yes	No	Year	Family History
Asthma:				
Inhaler type:				
Allergies:				
To medications/drugs				
To food				
To bee stings, insects, etc.				
To pollen, environment, etc				
Headaches (frequent)				
Heat Illness				
Blood disorders: sickle cell, etc				
Vision Problems				
Skin Infections				
Thyroid Conditions				
Cancer				
Absence of Paired Organ: Kidney, testicle, eye, etc				

GENERAL HEALTH	Yes	No	Year	Family History
Tuberculosis				
Diabetes				
Epilepsy/convulsions				
Mononucleosis				
Anemia				
Hepatitis				
Marfan's Syndrome				
ADD/ADHD				
Eating Disorders				
Cyst or Lumps				
Pain w/ menstrual periods				
Absent menstrual period				
Irregular Periods				
Last Menstrual period:				
Frequency:				
Duration:				

CARDIOVASCULAR	Yes	No	Year	Fam hx
Heart murmur				
Dizzy spells				
Fainting w/ exercise				
Double vision or loss of vision				
Myocarditis				

CARDIORESPIRATORY	Yes	No	Year	Fam hx
Chest pains				
Palpitations				
Shortness of breath				
High blood pressure				
Low blood pressure				

ABDOMINAL	Yes	No	Year	
Peptic Ulcer				
Stomach trouble, IBS, etc				
Rectal bleeding				
Hernia				
Appendicitis				
Spleen injury				
Kidney Stones				
Urinary Tract Infections				

NEUROLOGICAL	Yes	No	Year	
Head Injury				
Concussion				
Neck/Back injury				
Numbness in limbs				
Pinched nerve stingers, etc				
Herniated disc				
Seizures				
Depression and/or Anxiety				

DENTAL	Yes	No	Year	
Missing Teeth				
Bridge/Falls Teeth				
Hot/Cold Sensitivity				

EAR/NOSE/THROAT	Yes	No	Year	
Hearing difficulty				
Difficulty Breathing				
Nose Fracture				

