HEALTH SCIENCES Physical Examination Form

Last Name    First Name    GWid

Email     Phone     Date of birth (MM/DD/YYYY)     Term/Year First Admitted

Health Sciences Program (circle one):    Medical Lab Science     Physician Assistant     Physical Therapy

Physical Exam (Required annually for Health Sciences students engaging in clinical practice)

Age: _____     Height: _____     Weight: _______

Pulse: _____     Blood Pressure: _____/_____     Temp:_______

Vision: Uncorrected:  R____/____ L____/____ Both____/____

Corrected: R____/____ L____/____ Both____/____

<table>
<thead>
<tr>
<th>Normal Region</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears, Nose, Throat</td>
<td></td>
</tr>
<tr>
<td>Mouth, Teeth</td>
<td></td>
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<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Chest, Lungs</td>
<td></td>
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<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular</td>
<td></td>
</tr>
</tbody>
</table>

Remarkable Medical / Surgical History: __________________________________________________________
_______________________________________________________________________________________
________________________________________________________________________________________________________________________
GW HEALTH SCIENCES Physical Examination Form (cont’d)

Remarkable Family / Social History: ___________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Allergies: ______________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Medications: ____________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Last Name    First Name    GWid

Tuberculin Skin Test (Mantoux) – Required Annually

Date Placed ____/____/____   Date Read  ____/____/____    Result (in mm): ______________
(If positive ONLY) Result of Chest X-Ray: __________ Date of Chest X-Ray : ____/____/____

I certify this student:

- Has received a physical examination;
- Is found to be in good health and able to participate in classroom and clinical education components necessary to his/her program of study at the George Washington University.

____________________________________               _______________________                   _______________________________________
Health Care Provider Signature or Stamp                      Date                                                         Health Care Provider Phone Number

PA and PT Students – Please upload both pages of the completed form to your Certiphi myRecordTracker account.

MLS Students – Please upload both pages of the completed form and the Physician Statement of Essential Functions Form to your Certiphi myRecordTracker account.