

**Physician Assistant Studies  
Physical Examination Form**

7900 W. Division Street, River Forest, IL, 60171 | P: 708-524-6229 | Return to Wellness Center at *dom.edu/wellness*

Name: \_\_\_\_\_ Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**This section to be completed by health care provider**

Exam: Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_ P \_\_\_\_\_ BMI \_\_\_\_\_

Statement as to student's physical and mental status, any restrictions:

✓ Check = Normal	Note Variances, Abnormal or Significant Findings
<input type="checkbox"/> <b>Allergies:</b> Please note any allergies in the next column (medicines, foods, substances)	
<input type="checkbox"/> <b>General:</b> Healthy in appearance, no acute distress	
<input type="checkbox"/> <b>Skin:</b> Warm, pink, dry, with no rash or lesions	
<input type="checkbox"/> <b>Head:</b> Normcephalic; Normal hair growth	
<input type="checkbox"/> <b>Eye:</b> Sclera white, PERRLA	
<input type="checkbox"/> <b>Nose/Sinuses:</b> Sinuses non-tender to palpation, nares	
<input type="checkbox"/> <b>Ears:</b> No pain when helix pulled. External canal normal. TM with light reflex and landmarks present without erythema, injection, bulging, fluid, retraction, perforation, or drainage. No hearing loss.	
<input type="checkbox"/> <b>Pharynx:</b> Good dental hygiene, NO tonsillar hypertrophy, No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline	
<input type="checkbox"/> <b>Neck:</b> Supple with full ROM. No cervical adenopathy. No thyromegaly.	
<input type="checkbox"/> <b>Respiratory:</b> Respirations easy and non-labored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard.	
<input type="checkbox"/> <b>Cardiovascular:</b> Regular S1, S2 without murmur, gallop or run. No peripheral edema	
<input type="checkbox"/> <b>Abdomen:</b> Soft, non-distended with active bowel sounds x4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness or masses on palpation. No CVA tenderness	
<input type="checkbox"/> <b>Musculoskeletal:</b> Extremities with full ROM, no varicosities	
<input type="checkbox"/> <b>Neurologic:</b> Oriented x3. Cranial nerves II-XII intact	
<input type="checkbox"/> <b>Breast</b> Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed.	
<input type="checkbox"/> <b>Genitourinary:</b> External genitalia and hair distribution WNL. inguinal nodes WNL, no urethral lesions or tenderness	

**List all current medications:** \_\_\_\_\_

Yes  No Is this individual under care for a chronic or serious illness? If yes, attach letter of explanation/recommendations

**Provider's Signature:** \_\_\_\_\_ **MD, NP, PA, DO** **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** ( ) \_\_\_\_\_

**City/State/Zip** \_\_\_\_\_ **Fax:** \_\_\_\_\_