HISTORY OF PHYSICAL EXAMINATION FORM

THIS PAGE TO BE COMPLETED BY THE HEALTH CARE PROVIDER

APPLICANT'S FULL NAME:_____Date of Birth _____

REQUIRED - DISTANCE VISION:

If applicant ***does not*** wear glasses or contacts, please complete:

Uncorrected vision

Right 20/_____Left 20/ _____

If applicant ***wears*** glasses or contacts, please complete:

Corrected vision

Right 20/_____Left 20/ _____

CLINICAL EVALUATION (Check each item in appropriate column)

Normal	Abnormal		Normal	Abnormal	
		HEENT (Head, eyes, ears, nose, throat)			Abdomen
		Teeth and jaw			Skin (Describe any tattoos)
		Neck and thyroid			Spine, other musculoskeletal
		Ears (can hear whisper)			Upper extremities
		Eyes			Lower extremities
		Lungs and chest			Feet
		Heart – (sitting & lying exam)			Neurological
		Vascular System			

(REQUIRED) Blood Pressure_____Pulse _____

Remarks: (Describe every abnormality in detail.) _____

Are you aware of any psychological concerns now or in the past? YES_____**NO**_____**(If yes, describe in detail. Use additional sheet if necessary.)** _____

The student may participate in VMI's required boxing course? (Required) YES_____ **NO** _____

The student is cleared for full participation in NCAA athletics and required PE courses. (Required) YES_____ **NO**_____

How long has your practice known the patient? _____

Please see that ALL ITEMS ARE COMPLETED before returning this form.

Printed name_____ Telephone_____

Office address_____ Fax _____

_____ Signature_____MD/DO/NP/PA

City_____State_____Zip_____ Date _____