# 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 ________________________________________