California State University | NURSING | CHANNEL ISLANDS

Physical Examination

(This page must be completed by applicant)

Last Name:	**First Name:**	**Middle:**
DOB:	**Sex:**	**Student ID#:**

Medical History

Condition			Condition		
Abdominal Pain	☐ Yes	☐ No	Hernia	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
If yes, list:			High Blood Pressure	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Liver Disease/Hepatitis	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Surgery	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	If yes, date & type:		
Back Pain/Injury	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Ulcers/Gastritis/GERD	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No	Smoke	☐ Yes	☐ No
Epilepsy/Seizure	☐ Yes	☐ No	Packs per week:		
Headaches/Migraines	☐ Yes	☐ No	Alcohol Use	☐ Yes	☐ No
Head Injury/concussion	☐ Yes	☐ No	Drinks per week:	Drinks per month:	
Hearing Problems	☐ Yes	☐ No	Drug Use	☐ Yes	☐ No
Heart Disease/Murmur	☐ Yes	☐ No	Type/Frequency:		
Other:					

Current medications/herbs/supplements: ☐ Yes ☐ No If yes, list: ____

____

Who is your primary care physician? ____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, give the date and reason for hospitalization: ____

____

Have you ever failed a physical examination? ☐ Yes ☐ No

If yes, please explain reason(s): ____

This information may be shared with the department requesting Physical Examination and/or with the medical facility.

The above information is true and correct to the best of my knowledge.	
Print Name:	
Signature:	**Date:**

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cont. **Physical Examination**

(This page must be completed by Physician/Examiner)

Last Name:	**First Name:**	**Middle:**
DOB:	**Sex:**	

Height:	Weight:	B/P:	Pulse:	Resp:	LMP:
Vision Screening:	Right: 20/	Left: 20/	Both: 20/		
With Glasses:	Right: 20/	Left: 20/	Both: 20/		
Hearing Screening:	Right:		Left:		

EXAMINATION

Basic Exam		**Yes**	**No**	**Comments**
General:	Alert, well appearing, no apparent distress.	☐	☐	
Ears:	Canal without tenderness or exudate. TMs good landmarks/light reflex, no erythema.	☐	☐	
Sinus:	Patent nares; no sinus tenderness to palpitation.	☐	☐	
Pharynx:	No erythema, exudate; no tonsillar enlargement.	☐	☐	
Neck:	Supple, no adenopathy; no thyromegaly.	☐	☐	
Lungs:	Equal breath sounds; no respiratory distress; no wheezes, rhonchi or rales.	☐	☐	
Heart:	Regular rhythm, no murmurs, gallops or rubs.	☐	☐	
Abdomen:	Active BS; soft; no tenderness, guarding, masses or organomegaly; no CVA tenderness.	☐	☐	
Skin:	No rashes, petechiae or other lesions.	☐	☐	
Neuro:	DTRs + 2 bilaterally; strength 5 +/5+; Romberg negative.	☐	☐	
Back:	Straight, full ROM; non-tender to palpitation.	☐	☐	
Other:				

Physician/Examiner Print Name & Credentials:		
Physician/Examiner Signature:		Date:
Facility Name:		
Facility Address/Phone:		