



## **Physical Examination Record**

First Name	Middle Name		Last Name	
Date of Birth:		M#:		
This information will remain as part confidential at all times. The MSM- immunizations and physical examin Affairs if any health status issues of all immunizations questions to Stud	PA program re lation and the in change in the in	quires an annu mmediate not iterim. ** <b>Ple</b> a	nal updated r ification to to use upload for	nedical history, the Office of Student rm into Ace-Mapp and send
Student signature:				
To be completed and signe	d by health	icare provi	ider	
Print Name:				
First Height (Inches):		Middle ds):BP	:/	Last Pulse:
Vision: Right 20/	Left 20/_			
Enter "NE" if not evaluated				
Medical	Normal	Abnormal	Give detai	ils of each abnormality
Head, Neck, Face and Scalp				
Nose and Sinuses				
Mouth, Teeth, Gingiva and throat				
Ears -General (canals, drums, etc.)				
Eyes-General (lids, pupils, motions, etc.)	,			
Lungs, chest, and breasts				
Heart (include estimate of cardiac function)				
Vascular system (include varicosities)				
Abdomen and Vicera (include hernia)				
Anorectal and Pilonidal				

Continued on next page

Medical	Normal	Abnormal	Give details of each abnormality			
Endocrine System						
Genito-Urinary System						
Upper Extremities						
Lower Extremities						
Spine and other Musculoskeletal						
Skin and Lymphatic (include acne)						
Neurological System						
Psychiatric						
professional student in the classroom  If yes, please describe:  Any allergies to medications?  If yes, please describe:			No Yes			
Healthcare Provider Office Only						
Healthcare Provider's Name:						
Healthcare Provider's Signature:						
Address:						
City:						
Date of Examination:						

Student Health and Wellness Center (SHWC) 455 Lee Street SW Third Floor, Ste. 300A Atlanta, GA 30310

Ph: <u>(404) 756-1241</u>

Email: shwcrequests@msm.edu