

# Physical Exam



**Bay Path College**  
**588 Longmeadow Street**  
**Longmeadow, Ma. 01106**  
**413.565.1392 telephone**  
**413.565.1104 fax**

Student's name: \_\_\_\_\_  
Last First Middle

Social Security Number: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Telephone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

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## Medical history: If yes to any, please explain in area below

- |                           |     |                           |     |
|---------------------------|-----|---------------------------|-----|
| 1. Allergies              | Y N | 11. Hearing problems      | Y N |
| 2. Anemia                 | Y N | 12. Heart Disease         | Y N |
| 3. Asthma                 | Y N | 13. Heart Murmur          | Y N |
| 4. Bleeding disorder      | Y N | 14. Irregular Pulse       | Y N |
| 5. Collapsed lung         | Y N | 15. High Blood Pressure   | Y N |
| 6. Contact lenses/glasses | Y N | 16. Kidney Disease        | Y N |
| 7. Diabetes               | Y N | 17. Seizures              | Y N |
| 8. Enlarged Spleen        | Y N | 18. Psychiatric Disorders | Y N |
| 9. Eye problems           | Y N | 19. Eating Disorders      | Y N |
|                           |     | 20. Other _____           |     |

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

Family history of sudden deaths or strokes: \_\_\_\_\_

LMP: \_\_\_\_\_ Tobacco: \_\_\_\_\_ alcohol: \_\_\_\_\_

Chronic illness/surgeries/past hospitalizations:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\*\*\*\*\*Please see other side\*\*\*\*\*

**Physician:** Please review medical history with student and complete the information below.

Date of exam: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_

Hgb or Hct: \_\_\_\_\_ Medication allergies: \_\_\_\_\_

U/A: \_\_\_\_\_

**Physical Exam**

Are there any abnormalities of the following:

- |                             |     |                        |     |
|-----------------------------|-----|------------------------|-----|
| 1. Skin                     | Y N | 6. Cardiovascular      | Y N |
| 2. eyes, ears, nose, throat | Y N | 7. Genitourinary       | Y N |
| 3. Respiratory              | Y N | 8. Musculoskeletal     | Y N |
| 4. Teeth                    | Y N | 9. Metabolic/Endocrine | Y N |
| 5. Gastrointestinal         | Y N | 10. Neurologic         | Y N |

If yes to any of the above, please explain. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any restriction of activities/ sports/fitness center: \_\_\_\_\_

\_\_\_\_\_

Any problems that need follow-up or referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Student will be taking the following medications while at college: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_