CABRINI UNIVERSITY STUDENT HEALTH CENTER

PHYSICAL EXAMINATION FORM

610 King of Prussia Road Radnor, PA 19087 Phone: (610) 902-8531 • Fax: (610) 902-8282
Email: healthservices@cabrini.edu

Patient's Name:		**Date of Birth:**	

To the examining clinician: Please review the patient's history, complete this form and comment on all positive answers.

BP	/	Height		Weight	

Eyes	WNL	Remarks:	
Ears	WNL	Remarks:	
Nose	WNL	Remarks:	
Throat	WNL	Remarks:	
Neck	WNL	Remarks:	
Lungs	WNL	Remarks:	
Heart	WNL	Remarks:	
Abdomen	WNL	Remarks:	
Lymph glands	WNL	Remarks:	
G.U.	WNL	Remarks:	
Skin	WNL	Remarks:	
Neuro	WNL	Remarks:	
Musculoskeletal	WNL	Remarks:	

Current medical problems:_____

Current medications:_____

Summary of significant findings in history and physical exam:_____

Is this patient medically qualified to participate in intercollegiate, intramural or club sport activities? Yes____ No ____

This student has a history of: Addiction____ Depression____ Anxiety_____ Eating disorder_____ ADHD _____ None of these _____

Does this student have any disability? Yes___ No ___ Explain: _____

Does this student require any special accommodations for disability? Yes ___ No ___ Explain:_____

_____

Is this student under care for a chronic condition or serious illness? Yes ___ No ___ Explain:_____

_____

How long have you known this student? _____

Clinician's Signature: _____ Date Exam was completed:_____

Clinician's Printed Name:_____ Clinician's Address: _____

Clinician's Phone # _____Clinician's Fax # _____

Revised 2-3-20