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

CABRINI UNIVERSITY

Health History & Contact Form

(To be completed by the student)

PERSONAL INFORMATION (*Please print*)

Last Name _____ Legal First Name _____ Middle _____ Preferred Name _____

Address _____ City _____ State _____ Zip Code _____

(_____)_____ Student's Cell Phone _____/_____/_____ Date of Birth _____ Country of Birth

Emergency Contacts (Please list up to 3 people):

NAME	RELATIONSHIP	PHONE
1.		
2.		
3.		

I identify my gender as:

☐ Male ☐ Female Gender assigned at birth_____
☐ Transgender Man / Transman
☐ Transgender woman / Transwoman
☐ Genderqueer / Gender nonconforming

Additional identity (fill in):_____

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF THE **FRONT** & **BACK** OF YOUR HEALTH INSURANCE CARD SO WE HAVE IT ON FILE FOR LAB WORK. REFERRALS OR EMERGENCIES.

Policy holder name _____ Relationship to student _____

Health insurance carrier (Ex.: Aetna, Blue Cross, etc.) _____ Member ID # _____ Group # _____

MEDICAL HISTORY – *If **YOU** have a present or past history of the following, please check all that apply:*

☐ Alcohol abuse	☐ Drug abuse	☐ Intestinal /stomach trouble/ colitis	☐ Overweight / obesity
☐ Anemia	☐ Ear trouble / hearing loss	☐ Joint disease / injury	☐ Scarlet fever
☐ Anxiety	☐ Eating disorder	☐ Attention Deficit Hyperactivity Disorder	☐ Sexually transmitted infection (STI)
☐ Arthritis	☐ Eye disease / problems	☐ Menstrual problems	☐ Sickle Cell Trait / Anemia
☐ Asthma	☐ Gallbladder trouble	☐ Migraine headaches	☐ Sinus trouble
☐ Back problems	☐ Hay fever (recurrent)	☐ Mononucleosis, infectious	☐ Skin problems (chronic)
☐ Cancer	☐ Head injury	☐ Mumps	☐ Sleep problems
☐ Convulsions / seizures	☐ Headache (recurrent)	☐ Pneumonia	☐ Smoking (how long?) _____
☐ Cough (chronic)	☐ Heart disease / problems	☐ Paralysis	☐ Spleen, surgical removal
☐ Depression	☐ Hepatitis / jaundice	☐ PCOS	☐ Thyroid disease
☐ Diabetes	☐ Hernia / rupture	☐ Psychological counseling	☐ Tuberculosis
☐ Disability / Handicap	☐ High blood pressure	☐ Rheumatic fever	☐ Urinary tract infection

☐ Other: _____ ☐ NONE OF THE ABOVE

Current medications (list all, including birth control): _____

Allergies to drugs, foods, other? ☐ **Yes (list below)** ☐ **No** _____

Do you carry an EpiPen for any allergies? ☐ Yes ☐ No

Hospitalizations / surgeries: _____

FAMILY HISTORY (*Place relationship in blank*)

☐ Alcohol / drug abuse _____ ☐ Death before 50 _____ ☐ Elevated cholesterol _____ ☐ Hypertension / stroke _____
☐ Cancer / type _____ ☐ Diabetes _____ ☐ Heart disease _____ ☐ Mental illness _____

CONSENT FOR TREATMENT

By signature, I verify that the information provided on the form is true and I give permission for such diagnosis, therapeutic and operative procedures as may be deemed necessary for me.

_____ _____

Student Signature *Date*