



Physical Examination Record

First Name Middle Name LastName

Date of Birth: _____ M#: _____

This information will remain a part of the secured student file in Health Services Office and will remain confidential at all times. The MSM-PA program requires an annual updated medical history, immunizations and physical examination and the immediate notification to the Office of Student Affairs if any health status issues change in the interim. **Please upload form into Ace-Mapp and send all immunizations questions to Employee Health and Wellness Center at shwcrequests@msm.edu**

Student signature: _____

To be completed and signed by healthcare provider

Print Name: _____

First Middle Last
Height (Inches): _____ Weight (Pounds): _____ BP: _____ / _____ Pulse: _____

Vision: Right 20/ _____ Left 20/ _____

Enter "NE" if not evaluated

Medical	Normal	Abnormal	Give details 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 Viscera (include hernia)			
Anorectal and Pilonidal			

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Are there any conditions, physical and/or emotional, which may interfere with functioning as a health professional student in the classroom or clinic? No Yes

If yes, please describe: _____

Any allergies or medications? No Yes

If yes, please describe: _____

Healthcare Provider Office Only

Healthcare Provider's Name: EMC BT /45 0 WTj Q4 2 (thc)3.9 ()TJ 0 Tc 0 Tw >>BD3car >BD3car >BD3 3.78-6.