Ouachita Hills College

Report of Physical Exam

Students Name: _____ Date of Exam: _____

1. Height: _____Feet _____Inches Weight: _____Lbs. Blood Pressure: _____MmHg.

2. Vision: Uncorrected: RE 20/ _____ LE 20/ _____ Corrected: RE 20/ _____ LE 20/ _____

3. Pulse rate: Resting _____ After exercise _____ Three minutes after exercise _____

Normal	Clinical Evaluation	Abnormal	Comments
	4. Head, face, neck & scalp		
	5. Nose & sinuses		
	6. Mouth & throat		
	7. Teeth		
	8. Ears (+ drums)		
	9. Eyes		
	10. Lungs & chest		
	11. Heart & vascular system		
	12. Abdomen & viscera		
	13. Anus & rectum		
	14. Endocrine system		
	15. GU system		
	16. Extremities		
	17. Feet		
	18. Musculo - skeletal		
	19. Skin & lymphatic		
	20. Neurologic		
	21. Emotional		

22. Urinalysis: Sp.Gr. _____ Albumen _____ Sugar _____ Microscopic _____

23. Hemoglobin _____ PPD skin test: Date _____ Result _____

I attest that this individual is in overall good health and is free of any communicable diseases.

Name of Physician (print) _____

Physician Signature _____ Date _____ 20____

Mailing Address: _____ City _____

State _____ Zip _____ Country _____

YOUR PAST HISTORY. . .*Have you ever had:*

YES	NO		YEAR
☐	☐	Measles	
☐	☐	Mumps	
☐	☐	Chicken pox	
☐	☐	Whooping cough	
☐	☐	Polio	
☐	☐	Scarlet Fever	
☐	☐	Diptheria	
☐	☐	Meningitis	
☐	☐	Infectious mono	
☐	☐	Tuberculosis	
☐	☐	Exposure to TB	
☐	☐	Malaria	
☐	☐	Bronchitis	
☐	☐	Pneumonia	
☐	☐	Pleurisy	
☐	☐	Hepatitis (Jaundice)	
☐	☐	Bladder infection	
☐	☐	Rheumatic fever	
☐	☐	Kidney disease	
☐	☐	Kidney stones	
☐	☐	Glaucoma	
☐	☐	Cataracts	
☐	☐	Liver disease/trouble	
☐	☐	Gall Bladder trouble	
☐	☐	Seizures	

YES	NO		YEAR
☐	☐	Varicose veins	
☐	☐	Thrombophlibitis	
☐	☐	Gout	
☐	☐	Hay fever/ sinusitis	
☐	☐	Asthma	
☐	☐	Emphysema	
☐	☐	Arthritis	
☐	☐	Back trouble	
☐	☐	High blood pressure	
☐	☐	Heart disease	
☐	☐	Anemia	
☐	☐	Bleeding tendency	
☐	☐	Nose bleeds	
☐	☐	Ulcer	
☐	☐	Cancer	
☐	☐	Stroke	
☐	☐	Thyroid trouble	
☐	☐	Adrenal trouble	
☐	☐	Diabetes	
☐	☐	Lymes disease	
☐	☐	Aids (HIV Positive)	
☐	☐	Hemorrhoids	
☐	☐	Blood transfusion	
☐	☐	Gonorrhea, Syphilis	
☐	☐	Chronic Fatigue Syndrome	

Allergies:

YES NO

- ☐ ☐ Tetanus antitoxin
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa
- ☐ ☐ Other drug allergies

  _____

  _____
- ☐ ☐ Foods

  _____

  _____
- ☐ ☐ Other

  _____

  _____

Immunizations:

YES	NO		YEAR
☐	☐	Smallpox	
☐	☐	Tetanus	
☐	☐	Polio	
☐	☐	Mumps	
☐	☐	Pertussis	
☐	☐	Diphtheria	
☐	☐	Measles	

Injuries:

YES	NO		YEAR
☐	☐	Head	
☐	☐	Chest	
☐	☐	Abdomen	
☐	☐	Broken bones	
		_____	
		_____	
		_____	
☐	☐	Back	
☐	☐	Other	
		_____	
		_____	
		_____	

Operations:

YES	NO		YEAR
☐	☐	Tonsils	
☐	☐	Appendix	
☐	☐	Gall bladder	
☐	☐	Stomach	
☐	☐	Breast	
☐	☐	Uterus/ovary	
☐	☐	Prostate	
☐	☐	Hernia	
☐	☐	Thyroid	
☐	☐	Varicose veins	
☐	☐	Hemorrhoids	
☐	☐	Heart	
☐	☐	Other	
		_____	

Have you or **do** you partake(n) any of the following?

HAVE	DO		HAVE NOT SINCE
☐	☐	Alcohol	
☐	☐	Tobacco	
☐	☐	Tea	
☐	☐	Coffee	
☐	☐	Soft drinks	
☐	☐	Colas	
☐	☐	Drugs	

Usual recreational activity: _____

Hours/week viewing TV: _____

Exercise (type & frequency): _____

Do you take any medications or supplements?

Name	*Dosage*	*Duration*