Name: _____

PUC ID#: _____

PHYSICAL EXAMINATION

The following to be completed by doctor's office staff. All information below is required. Please do not leave any section blank. We cannot accept "not applicable" in any category listed below.

Height: _____ **Weight:** _____

Hearing Evaluation:

Right: _____ Left: _____

Vision Screening:

Without glasses/With glasses (circle)

Right: _____ / _____

Left: _____ / _____

Vital Signs:

T: _____

P: _____

R: _____

B/P: _____

TB Test (within the last year)

Lot #: _____ Exp.: _____

Date given: _____ Date read: _____

Induration/reading: _____

Read by: _____

If you have recently been out of the United States, please have one done now. PPD must be negative-10mm or less.

Date of last chest X-ray: _____

Results: _____

Current Medications: _____

_____

Nurse's Signature: _____

Remarks (please describe each abnormality): _____

_____

_____

_____

_____

_____

Date of examination: _____

To be filled out by physician:

Normal	Clinical Evaluation	Abnormal
	Head, Face, & Scalp	
	Nose & Sinuses	
	Neck	
	Mouth & Throat	
	Ears	
	Eyes	
	Lungs & Chest	
	Breast	
	Heart	
	Vascular System	
	Abdomen	
	Rectum	
	Endocrine	
	G.U. System	
	Extremities	
	Musculoskeletal	
	Skin	
	Neurological	
	Emotional	

Physician's Signature: _____ Date: _____

Name of physician: _____ Street Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

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