PENNSTATE
Milton S. Hershey Medical Center
College of Medicine

OFFICE OF STUDENT HEALTH

Name _____ **Date:** _____

Physical Examination

Vital Signs: BP _____/_____, Pulse _____, Ht. _____", Wt. _____lbs.

Check abnormal items and describe in detail.

	Normal	Abnormal	
Skin:	☐	☐	(hair/nails/scars)
Eyes:	☐	☐	(lids/pupils/conjunctivitis/cornea/fundi)
Ears/Nose:	☐	☐	(pinna/canal/drum/hearing/nasal mucosal)
Oropharynx:	☐	☐	(teeth/gums/mucosal/tonsils/pharynx)
Neck:	☐	☐	(motion/thyroid/masses/nodes)
Heart:	☐	☐	(pulses/rate/rhythm/murmurs)
Breasts:	☐	☐	(fibrocystic changes/masses)
Lungs:	☐	☐	(breath sounds)
Abdomen:	☐	☐	(scars/tenderness/bowel sounds/masses/organs)
Ortho:	☐	☐	(spine/joints/mobility)
Extremities:	☐	☐	(peripheral pulses/venous return)
Neuro:	☐	☐	(mental status/speech/motor/sensory/reflexes/coordination)
Male Genital:	☐	☐	(testicular/hernia/lesions)
Pelvic/Rectal:	☐	☐	Pap last performed (Date)_____ ☐ Deferred

Assessment:

Physician/Health Care Provider Signature:_____

Physician/Health Care Provider Name (please print) _____

Address: _____

_____

Phone: _____