Keene STATE COLLEGE Wisdom to make a difference.

Nursing Program
229 Main Street
Keene, NH 03435-3801
(603) 358-2533

PHYSICAL EXAMINATION FORM

Must have been completed within the last year.

Full Legal Name: _____

Date of Birth: ____ / ____ / ____ (M / D / Y) Sex: F ☐ M ☐ T ☐

Blood Pressure: _____ Pulse: _____ Weight: _____ Height: _____ BMI: _____

Visual Activity: OD 20/ _____ OS 20/ _____ Corrective Lenses: with ☐ without ☐

History		Yes	No
1.	Allergies (food, medicine, other)	☐	☐
2.	Concussion(s)	☐	☐
3.	Orthopedic Injury	☐	☐
4.	Prior exertional chest pain	☐	☐
5.	Excessive, unexplained shortness of breath or fatigue with exercise	☐	☐
6.	Prior history of heart murmur or increased blood pressure	☐	☐
7.	Prior exertional syncope or near syncope	☐	☐
8.	Family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50	☐	☐

If you answered "yes" to any of the history points above, please explain.

Exam – "WNL" or note abnormalities	
Psychological	
Derm	
HEENT	
Neck/Thyroid	
Respiratory	
Cardiac	
Gastro/Intestinal	
Extremities	
Neurological	
Genitals/Hernia	

Laboratory (if indicated)

HGB/HCT: _____

Urine (dip): _____

Sickle Cell Screening Results: _____

Healthcare Provider (print name): _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Signature: _____ Fax: _____