Wheeling Jesuit University ◆ Doctor of Physical Therapy Program

ANNUAL PHYSICAL FORM

YOUR PHYSICIAN OR NURSE PRACTITIONER MUST COMPLETE, SIGN, AND DATE THIS FORM.

PLEASE PRINT
STUDENT NAME: _____ _____ _____ **DATE OF BIRTH:** _____
Last First Middle Initial

Family history:
Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

❑ Cancer ❑ Diabetes ❑ Asthma, Hay Fever, or other Allergies
❑ Heart Disease ❑ Marfan's Disease ❑ Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies: _____

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

LIST MEDICATIONS: _____

Normal	Abnormal	Notes of Abnormality
_____Skin	_____	
_____Hearing	_____	
_____Head	_____	
_____Ear, Nose, & Throat	_____	
_____Neck: Thyroid	_____	
_____Cardiovascular	_____	
_____Lungs	_____	
_____Breasts	_____	
_____Abdomen	_____	
_____Genitalia	_____	
_____Menstruation	_____	
_____Back & Extremities	_____	
_____Reflexes	_____	

_____ Student must be able to lift up to 50 pounds. Does this student meet this qualification? _____

ALLERGIES/REACTIONS: No known allergies: _____
Latex: _____ food: _____

dyes: _____ medication: _____

(REQUIRED RESPONSE) Does this student have any past or current physical or emotional conditions that you consider important?

_____

(REQUIRED RESPONSE) Is this student presently under medical therapy or psychological counseling?

_____

Recommendations: _____

Name of Physician OR NP (print): _____ ▼OFFICIAL OFFICE STAMP▼

Phone: [_____]_____ Fax: [_____]_____

Address: (Street) _____(City)_____ (State) ___ (Zip) _____

Signature of Physician OR NP: _____ Date: _____

Revised 04/28/2015