PHYSICAL EXAMINATION FORM
(To be completed by Physician or Nurse Practitioner)

Name: ____ Date ____________
Last First Middle

Height ______ Weight ______ Temp _______ BP ______ P:______ Resp _____ Sex ____ DOB/ Age _______

Vision: Last eye exam: ____________ R ___________ L___________ with glasses? ______ with contacts? ______

HISTORY:
(Include any significant information regarding previous medical and surgical conditions, and use of alcohol and/or drugs.)

General Appearance

____

Normal	Abnormal	Check each item in appropriate column	Describe every abnormality in detail (Attach sheet if necessary)
		Eyes-ears-nose-throat	
		Mouth-teeth-neck	
		Thyroid	
		Heart and vascular	
		Lungs	
		Abdomen and Viscera	
		Hernia (if indicated)	
		Scars	
		Back, Vertebrae	
		Rectal, anus (If indicated)	
		Extremities	
		Skin	
		Neurological	
		OTHER:	
		OTHER:	

OVER

LABORATORY DATA: (Specific lab findings, when necessary for diagnostic purposes.)

Name of Test ________________________ Results ____

Name of Test ________________________ Results ____

RECOMMENDATIONS BASED ON YOUR PHYSICAL EXAMINATION

Is applicant free of any restrictions in his/her ability to turn and/or move heavy objects? Yes _______ No _______
If no, please describe:

Is the applicant able to see and hear adequately to practice a health care profession safely? Yes _______ No _______
If no, please explain:

Is the applicant free of any pathological conditions, either physical or mental, which would interfere with the practice of a health profession? Yes _______ No _______
If no, please describe:

____ ____

Signature of Physician, Physician's Assistant or Nurse Practitioner Date

____ ____

Address of Physician, Physician's Assistant or Nurse Practitioner: Telephone of Physician, Physician's Assistant or Nurse Practitioner

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PLEASE RETURN THIS FORM TO:

OCCUPATIONAL THERAPY ASSISTANT PROGRAM
GROSSMONT COLLEGE
8800 GROSSMONT COLLEGE DRIVE
EL CAJON, CA 92020-1799
(619) 644-7304 Phn
(619) 644-7961 Fax

Please affix business card or office stamp here.