

**Dominican University of California  
Student Health Center  
50 Acacia Ave  
San Rafael, CA 94901  
(415) 485-3208**

**Physical Examination Form for Students Living on Campus**

**Patient Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**To the examining clinician:**

This student has already been accepted for admission to Dominican University of California. Thus, information concerning medical, communicable and psychiatric disorders is needed for giving well-informed healthcare to the student and to ensure the safety of all resident students.

Please complete this form, as well as the form entitled "Immunization & TB Screening". Your recommendations will be appreciated.

Thank you. ~ Student Health Center Director

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision: uncorrected R \_\_\_\_\_ L \_\_\_\_\_ corrected R \_\_\_\_\_ L \_\_\_\_\_

Normal	Abnormal/variant	Describe findings:
<input type="checkbox"/>	<input type="checkbox"/>	General/Skin _____
<input type="checkbox"/>	<input type="checkbox"/>	HEENT _____
<input type="checkbox"/>	<input type="checkbox"/>	Neck _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart/CV _____
<input type="checkbox"/>	<input type="checkbox"/>	Lungs/chest/breasts _____
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen _____
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal _____
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic _____
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary tract _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Behavioral _____

Additional findings: \_\_\_\_\_

Medications: \_\_\_\_\_

Problem List/ Diagnoses: \_\_\_\_\_

Recommendations (treatment, instructions, referrals needed): \_\_\_\_\_

Restrictions/ Limitations/ Accommodations: \_\_\_\_\_

**Health Care Provider:** \_\_\_\_\_

(Print Name)

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_