

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 _____

Additional findings: _____

Medications: _____

Problem List/ Diagnoses:

Recommendations (treatment, instructions, referrals needed):

Restrictions/ Limitations/ Accommodations :

Health Care Provider: _____
(Print Name)

Address: _____

Phone: _____ **Email:** _____

Signature: _____ **Date:** _____