Sullivan University
College of Pharmacy

PHYSICAL EXAMINATION FORM

Patient's Name ______________________________________ DOB: _______________ SSN: ____________________

Height ________ Weight ________ Temp. ________ Pulse ________ Resp. ________ Blood Pressure: ____________

Patient Wears	Distant Vision	Near Vision
Glasses ____ Contact Lenses____	Right 20/ Corr. to 20/ Left 20/ Corr. to 20/	Right 20/ Corr. to 20/ Left 20/ Corr. to 20/
Color Vision	**Urine**	
Test used and result:	Spec. Gravity: Protein: Glucose:	

TO BE FILLED OUT BY PHYSICIAN

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES BELOW
General Appearance			
Head and Neck			
Scalp and Face			
Eyes			
Pupils, Ocular Motility			
Nose and Sinuses			
Mouth and Throat			
Teeth			
Ears, Tympanic Membrane			
Thyroid			
Lungs			
Heart			
Peripheral Vascular System			
Abdomen			
Genitalia			
Hernia			
Spine (R.O.M., pain, abnormal curves)			
Upper Extremities			
Lower Extremities			
Skin			
Lymphatic System			
Neuromuscular System			

Patient's Name ________________________________ **DOB:** _____________ **SSN:** __________________

HEALTH HISTORY

Please circle any history of the following and explain, if necessary

Severe Headaches/Head Injury	
Stroke/Seizure Disorder	
Hearing Loss/Ringing in Ears	
Glasses/Contact Lenses/Glaucoma	
Thyroid Disease/Diabetes	
Asthma/Emphysema	
Heart Attack/Heart Failure	
High Blood Pressure/Heart Arrhythmia	
Stomach Ulcers/Reflux Disease	
Liver Disease/Gallstones	
Kidney Disease/Kidney Stones	
Female GYN/Disorder (including Breast)	
Male Urology Disorder (including Prostate)	
Sexually Transmitted Disease	
Arthritis/Gout	
Fractures/Dislocations	
Hay Fever/Chronic Skin Rash	
Cancer/Blood Disorder/Anemia	
Smoking/Drugs/Alcohol Usage (or Quit Dates)	
Other Illnesses	

PLEASE LIST ANY BELOW THAT APPLY

Surgeries/Hospitalizations	**Regular Medications**	**Medication Allergies**

IMMUNIZATION HISTORY AND UPDATES (List Below or Attach Separate Immunization Sheet)

MMR		
Hepatitis (Hib)		
Polio		
Tetanus		
TB		

____ ____________________________

Signature Date

Printed (or Stamped) Name and Address: