NAU NORTHERN ARIZONA UNIVERSITY
College of Nursing

Physical Examination Form

You are required to have a licensed health care provider perform a physical exam and discuss your medical history with you prior to entry into the nursing program.

Name _____ Date of Birth _____ ☐ Male ☐ Female

Date: _____

1. Height: _____ Weight: _____ Posture: _____ BP: _____
2. Ears: Hearing (low conversational voice) R _____ L _____
   Inspection including tympanum: R _____ L _____
3. Nose and Throat: _____
4. Mouth and Teeth: _ Caries _____ Missing Teeth: _____
5. Cardiovascular: Heart Sounds: _____ Pulse: _____
   Varicosities? _____
6. Abdomen: _____ Hernias: _____
7. Glandular System: Lymph: _____ Thyroid: _____ Mammary: _____
8. Bones, Joints & Muscles: _____
9. Nervous System, including tendon reflexes and gross coordination:

   _____
10. Skin: _____
11. Limitations or Restrictions on physical activity, diet, etc? Why?

_____

_____

_____

Upon completion of physical exam please fill out the Healthcare Provider Certificate and verify that the exam date is filled out.

Upload page 1 of physical exam and the Healthcare Provider Certificate to Exxat.

Personal medical history on reverse page.

Provider to review and comment on all yes answers in space below.

Student/Patient Personal History - Please answer all questions.

Name _____ **Date of birth** _____ **Exam Date:** _____

HAVE YOU HAD?	Yes	No	HAVE YOU HAD?	Yes	No
Eczema	☐	☐	Shortness of breath	☐	☐
Acne	☐	☐	Asthma	☐	☐
Head Injury with Unconsciousness	☐	☐	Chronic Cough	☐	☐
Dizziness or Fainting	☐	☐	Cystic Fibrosis	☐	☐
Eye Trouble	☐	☐	Chest Pain	☐	☐
Ear Problems	☐	☐	Palpitations (Heart)	☐	☐
Hearing Difficulty	☐	☐	Rheumatic Fever	☐	☐
Nose Problem	☐	☐	Heart Murmur	☐	☐
Sinusitis	☐	☐	High Blood Pressure	☐	☐
Hay fever	☐	☐	Low Blood Pressure	☐	☐
Gum or Tooth Trouble	☐	☐	Anemia	☐	☐
Throat Problem	☐	☐	Sickle Cell	☐	☐
Neck Injury	☐	☐	Bleeding Disorder	☐	☐
Do you smoke?	☐	☐	Stomach Trouble	☐	☐
Do you use marijuana?	☐	☐	Intestine Trouble	☐	☐
Bronchitis	☐	☐	Gall Bladder Trouble	☐	☐
Pneumonia	☐	☐	Jaundice	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐
HIV Infection Exposure	☐	☐	Recurrent Diarrhea	☐	☐
Recurrent Constipation	☐	☐	Malaria	☐	☐
Recent Weight Gain	☐	☐	Chicken Pox	☐	☐
Hernia	☐	☐	Diabetes	☐	☐
Hemorrhoids	☐	☐	Thyroid Problem	☐	☐
Do you drink alcohol?	☐	☐	Tumor, Cancer, Cyst	☐	☐
Back Problems	☐	☐	Sexually Transmitted Disease	☐	☐
Disease/Injury of Joints	☐	☐	Herpes	☐	☐
Bladder Infection	☐	☐	**FEMALES ONLY:**	☐	☐
Kidney Infection	☐	☐	Irregular periods	☐	☐
Weakness, Paralysis	☐	☐	Severe Cramps	☐	☐
Seizures	☐	☐	Excessive Flow	☐	☐
Recurrent Headaches	☐	☐	Abnormal PAP	☐	☐
Insomnia	☐	☐	Pregnancy	☐	☐
Frequent Anxiety	☐	☐	Cystic Breasts	☐	☐
Frequent Depression	☐	☐	**MALES ONLY:**	☐	☐
Worry or Nervousness	☐	☐	Prostate Problems	☐	☐
Mononucleosis	☐	☐	Lump or Mass in Testicle	☐	☐

Comments _____