

# Oklahoma Wesleyan University Physical Examination

To be completed by Healthcare Provider

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Visual Acuity:  
 OD \_\_\_\_\_ OS \_\_\_\_\_ OU \_\_\_\_\_ Hearing: \_\_\_\_\_

Suggested Laboratory Tests:  
 Urinalysis: \_\_\_\_\_ Within Normal Limits \_\_\_\_\_ Abnormal If abnormal, explain: \_\_\_\_\_

Hemoglobin: \_\_\_\_\_ Within Normal Limits \_\_\_\_\_ Abnormal If abnormal, explain: \_\_\_\_\_

## CLINICAL EVALUATION

	Normal	Abnormal	Comments
1. Head, Ears, Nose, Throat			
2. Mouth, Teeth, Gums, Tonsils			
3. Neck and Thyroid			
4. Lungs / Chest			
5. Skin			
6. Heart			
7. Abdomen			
8. Genitalia			
9. Back/ Spine/ Bones/Joints			
10. Extremities / Musculoskeletal			
11. Neurological Motion Condition			
12. Emotional / Psychological			
13. Feet			
14. Other Findings			

Loss of Paired organ function: \_\_\_\_\_ No \_\_\_\_\_ Yes If yes, please explain: \_\_\_\_\_

Recommendation for physical activities,  
 including participation in club, \_\_\_\_\_ Unlimited \_\_\_\_\_ Limited If limited, please explain: \_\_\_\_\_  
 intramural & intercollegiate sports:

Signature of Healthcare Provider \_\_\_\_\_ Date \_\_\_\_\_

Print name of Healthcare Provider \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_