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: ________________

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Hemoglobin: _____Within Normal Limits ____Abnormal if abnormal, explain_________________

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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, intramural & intercollegiate sports:
____Unlimited ____Limited If limited, please explain: ________________________________

____
Signature of Healthcare Provider Date

____
Print name of Healthcare Provider

____
Address Telephone Fax