

# PHYSICAL EXAMINATION FORM

## Student Health Services

Bethune-Cookman University  
640 Dr. Mary McLeod Bethune Blvd.  
Daytona Beach Florida 32114  
(386) 481-2920  
Fax (386) 481-2923

Name: \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Vision \_\_\_\_\_ Corrected Y N

Exam: Normal Abnormal Comments on abnormal findings

Exam:	Normal	Abnormal	Comments on abnormal findings
Appearance			
Head/Neck			
Eyes/Ears/Nose/Throat			
Heart			
Lungs			
Skin			
Abdomen			
Genitalia			
Extremities			
Musculoskeletal			
Receiving treatment for Chronic medical or psychological condition (explain)			
Tuberculosis screening (if high risk for disease)			

Name of Physician or Provider \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature and Provider Stamp: \_\_\_\_\_