College of the Holy Cross Health Services

PHYSICAL EXAMINATION FORM

Legal name ____ Date of Birth _____________ Date ____________
Preferred name__________________________________ Sex at birth ____________ Gender _____________
Pronouns ______/_____/_____
Does applicant have any past/ current medical problems? □ yes □ no Tb risk □ low □ high
If yes, please describe: ____
____
____
Does the applicant have a history of past/current emotional or psychological problems? □ yes □ no
If yes, please describe: ____
____
Has applicant been hospitalized in the past? □ yes □ no
If yes, please describe: ____
____
____
Does the applicant have a history of a concussion? □ yes □ no If yes, how many? _______
Describe recovery: ____
Neuro testing done? □ yes □ no Cleared for high risk sports? □ yes □ no

List pertinent family history: ____
____
Current Medication(s) with dosage: ____
____
Medication Allergies: ____
Reaction to Allergies: ____
Food Allergies: ____
Any other Allergies? □ yes □ no If yes, describe: ____

History of systemic reaction to food allergen? □ yes □ no
History of Celiac disease or medically documented gluten intolerance? □ yes □ no
(If yes, include lab tests, biopsy results, treatment plan and/or history of disease) If accommodations are needed contact the Office of Accessibility Services at 508-793-3693.

Height ________ Weight ________ BMI ______ Pulse ______ BP ____/____ Vision R 20/ _____ L 20/ _____

	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart		
Murmurs		
Pulses		
Lungs		
Abdomen		
Genitourinary		
Skin		
Musculoskeletal		
Neurological		

The applicant ☐ should ☐ should not have additional ☐ medical ☐ psychological follow-up
☐ cleared without restriction ☐ cleared for intramural / club sports
☐ cleared with recommendations. Treatment plan: ____
____
____
Healthcare provider: ____
Please print Last First NP, MD, DO

Address ____ ___________________________

Phone # ______________________ fax # ______________________

Signature of Healthcare provider: ____