H&C HEALTH & COUNSELING

Lauderdale Center for Student Health & Counseling
SUNY Geneseo, 1 College Circle, Geneseo, NY 14454
Health Services (585) 245-5736 ◆ Counseling Services (585) 245-5716
Fax (585) 245-5744

Administrative Use Only. Do NOT write in this box.

☐COMPLETE ☐INCOMPLETE
RN REVIEWED_____
LETTER SENT REQUESTING ☐IMM ☐OTHER
DATA ENTRY_____

Physical Exam *(to be completed by your Physician or Health Care Professional)*

Please be sure to attach an updated Immunization Record and Insurance Information

Check ALL Applicable Boxes

Freshmen: A physical exam must have been completed within the past year
Semester/Year you are entering: Fall 20_____ Spring 20_____ Summer 20_____
Transfer Students & Grad Students: A physical exam must have been completed within the past two years
☐Transfer : Fall 20_____ Spring 20_____ Summer 20_____
☐Graduate: Fall 20_____ Spring 20_____ Summer 20_____
Part-Time Students & Grad Students who graduated from SUNY Geneseo within the past year: A physical exam is not required- Do not complete this page.

Last Name First Name D.O.B G00#

Height: ft. in. Blood Pressure: Pulse:

Weight: lbs. Waist Circumference:

Vision: Far: Right 20/ Corr.to 20/ Far: Left 20/ Corr. To 20/

Lab Data: Hct. % Serum Cholesterol mg Urinalysis: Alb. Sug. Micro.

Clinical Evaluation

Check each item in proper column. Enter N.E. if not evaluated.	✓ **Normal**	✓ **Abnormal**	Give details of each abnormality with corresponding item number.
1. Head, Neck Face and Scalp			
2. Nose and Sinuses			
3. Mouth and Throat			
4. Ears (perf of drum, etc.)			
5. Eyes (lids, conjunctiva, etc.)			
6. Pupils and Ocular Motion			
7. Lungs			
8. Heart			
9. Vascular System (varicosities, etc.)			
10. Abdomen and Viscera (include hernia)			
11. Breasts / Pelvic Exam			
12. Endocrine System			
13. G-U Male			
14. Upper Extremities (strength, range of motion)			
15. Lower Extremities (as for upper)			
16. Spine, other Musculo-Skeletal			
17. Skin and Lymphatics			
18. Neurologic			
19. Psychiatric (specify)			
20. Is there loss or seriously impaired function of any paired organ? ☐ Yes ☐ No			

	Yes	No	
21.	☐	☐	Any recomnmendations for special dietary requirements or limitation of physical activity?
22.	☐	☐	Is this individual under care for a chronic condition/serious illness? If yes, please enclose further information.
23.	☐	☐	Any known allergies? List below.

COMMENTS:

Tubersculosis Screening – PPD (Mantoux) required if answers YES to any of the following:

Yes	No	
☐	☐	Lives or works with someone who has Tuberculosis
☐	☐	Born outside of the United States, Canada, or Europe
☐	☐	Immunocompromised or injects recreational drugs
☐	☐	Healthcare worker or lived/woked in a nursing home, prison, or residential institution
☐	☐	Received the BCG vaccine

Date PPD placed _____ Date Read_____ Result _____(mm induration)

If poistive PPD, Chest x-ray and a copy of the report is required. CXR date_____

Yes	No	Refused	
☐	☐	☐	If positive PPD and negative CXR, treatment for latent TB infection was offered

Medication and duration of treatment _____

Other _____

Must be signed by your health care provider

Upon completion of a complete physical examination I have found this student capable of participating in a full program of college study, including participation in intercollegiate sports, and that the **immunization record (enclosed)** is accurate.

HEALTH CARE PROVIDER SIGNATURE: X_____ **Date:**_____

Please Print or Type Name of
Physician or Health Care Facility: _____

Address:_____ Phone: ( )_____

_____ Fax: ( )_____

HEALTH INSURANCE: * Please submit a copy of your INSURANCE CARD (front & back) *****

Medical Insurance Company:_____ Policy #:_____

Address:_____

Subscriber Name: _____