

## PHYSICAL EVALUATION

**CERTIFIED AS A MEDICAL HOME:** The Department of Student Health and Counseling (SHC) at SUNY Geneseo has received Accreditation as a MEDICAL HOME. A MEDICAL HOME is student-centered, comprehensive, team-based, accessible, and quality focused. Allow us to be part of your health care team. We need your detailed health history, recent physical exam, and immunization records in order to coordinate with your health care providers to offer you the best medical care. Student Health and Counseling, your "MEDICAL HOME Away From Home".

Name: _____	DOB: _____	Geneseo ID Number: G00 _____
Phone #: _____	Email: _____	

<p>BP _____ HR _____ RR _____</p> <p>Height: ___ feet ___ inches BMI _____</p> <p>Weight: _____ pounds Waist Circumference _____</p> <p>Vision: Uncorrected or Corrected OD _____ OS _____ OU _____</p>		<p><b>ALLERGIES</b> (medications, food, latex, other):</p> <p>_____</p> <p>_____</p> <p><b>Medication</b> (Including OCP, IUD, monthly injections, Psychiatric medications):</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	--	---

**Clinical Evaluation – Describe each abnormality in the space provided**

Enter N/A if not evaluated	NORMAL √	ABNORMAL FINDINGS
Head, Neck Face and Scalp		
Nose and Sinuses		
Mouth and Throat		
Ears (perf of drum, etc.)		
Eyes (lids, conjunctiva, etc.)		
Pupils and Ocular Motion		
Lungs		
Heart		
Vascular System (varicosities, etc.)		
Abdomen and Viscera (include hernia)		
Breasts / Pelvic Exam		
Endocrine System		
G-U Male		
Upper Extremities (strength, range of motion)		
Lower Extremities (as for upper)		
Spine, other Musculo-Skeletal		
Skin and Lymphatics		
Neurologic		
Psychiatric (specify)		

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Geneseo ID Number: G00 \_\_\_\_\_

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there loss or seriously impaired function of any paired organ? <b>(If yes, comment below)</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any recommendations for special dietary requirements or limitation of physical activity?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	To the best of your knowledge, is this person free from physical/mental impairments, including alcohol or drug dependency.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Immunization records provided to student?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	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.

**COMMENTS:**

**CERTIFIED AS A MEDICAL HOME:** The Department of Student Health and Counseling (SHC) at SUNY Geneseo has received Accreditation as a MEDICAL HOME. A MEDICAL HOME is student-centered, comprehensive, team-based, accessible, and quality focused. Allow us to be part of your health care team. We need your detailed health history, recent physical exam, and immunization records in order to coordinate with your health care providers to offer you the best medical care. Student Health and Counseling, your "MEDICAL HOME Away From Home."

**Must be signed by health care provider (physician, NP or PA:)**

<p>Today's Date: _____ MONTH/DAY/YEAR</p> <p>Provider Signature: _____</p>	<p align="center"><b>PRINT or STAMP information below</b></p> <p>Provider Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p>
--	---

*Certified as a Medical Home by*



ACCREDITATION ASSOCIATION  
*for* AMBULATORY HEALTH CARE, INC.