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:_____ Exam Date: _____

BP _____ **HR** _____ **RR** _____

Height: ____ feet ____inches **BMI** _____

Weight: _____ pounds **Waist Circumference** _____

Vision: Uncorrected or Corrected
OD _____ OS _____ OU _____

ALLERGIES (medications, food, latex, other):
_____
_____

Medication (Including OCP, IUD, monthly injections, Psychiatric medications):
_____
_____
_____

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)		

Accredited as a Medical Home by AAAHC ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Health Services
Phone: 585.245.5736
Fax: 585.245.5744

Counseling Services
Phone: 585.245.5716
Fax: 585.245.5071

Alcohol & Other Drug Services
Phone: 585.245.5716
Fax: 585.245.5071

Health Promotion
Phone: 585.245.5747
Fax: 585.245.5744

Name: _____ DOB:_____ Geneseo ID Number: G00_____

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

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

Today's Date: _____ MONTH/DAY/YEAR **Provider Signature: _____**	**PRINT or STAMP information below** **Provider Name: _____** **Address: _____** **_____** **Phone #: _____**

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