PHYSICAL EVALUATION

We need your detailed health history, recent physical exam, and immunization records in order to coordinate with your health care providers to offer the best medical care.

Patient to complete this box:

Name: _____ DOB:_____ Geneseo ID Number: G00_____

Phone #: _____ Email:_____

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

Height: ____ feet ____inches **BMI** _____

Weight: _____ pounds **Waist Circumference** _____

Vision: Uncorrected or Corrected:

OD _____ OS _____ OU _____

ALLERGIES (medications, food, latex, other):

Medications (Including Birth Control, IUD, monthly injections, Psychiatric medications):

Clinical Evaluation – Describe each abnormality or history (ex. Asthma, ITP, cardiac, etc.) in the space provided or in the comments section on page 2

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	☐	

Achieved Accreditation by AAAHC

Health Services
Phone: 585.245.5736
Fax: 585.245.5744

Counseling Services
Phone: 585.245.5716
Fax: 585.245.5071

Health Promotion
Phone: 585.245.5747
Fax: 585.245.5744

Patient to complete this box:
Name: _____ DOB:_____ Geneseo ID Number: G00_____

Mental Health: ☐ Anxiety ☐ Depression ☐ Other:
COMMENTS:

Please read carefully and respond to the following. There is space below for comments.

1.	☐ Yes	☐ No	Does this patient have any newly diagnosed conditions OR a health issue that is currently being studied/is pending? **(If yes, comment below, or attach summary)**
2.	☐ Yes	☐ No	Is there loss or seriously impaired function of any paired organ? **(If yes, comment below)**
3.	☐ 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 Physician, NP, or PA:	**PRINT or STAMP information below**
Exam Date: _____ **MONTH/DAY/YEAR**	**Provider Name:** _____
Today's Date: _____ **MONTH/DAY/YEAR**	**Address:** _____
Provider Signature: _____	**Phone #:** _____

When completed, upload to your health portal at https://myhealth.geneseo.edu

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