WICHITA STATE UNIVERSITY
STUDENT HEALTH SERVICES

Phone: (316) 978-4792
Fax: (316) 978-3517
Web: wichita.edu/shs

Mailing Address:
1845 Fairmount, Box 92
Wichita, KS 67260-0092

PHYSICAL EXAMINATION

Patient _____ DOB: _____
Last Name First MI

WSU ID# _____ Phone # _____

Medical History:

Last date of eye exam: _____
Last date of dental exam: _____
Any major illness or health impairment: _____
Hospitalization/Serious Injury: _____
Patient's past history: _____
Any mental or behavioral health history? ____Yes____No _____
Any findings in patient's family health history? _____
Allergy _____
Latex/non-medication allergies _____Yes _____No If yes, specify: _____
Medications currently being taken: _____

Physical Examination (notate all spaces, draw-through lines are not acceptable):

Examined:	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Appearance	____	____	HEENT	____	____	Breasts	____	____	Abdomen	____	____
Neurological Exam	____	____	Heart	____	____	Lymph Nodes	____	____	GU Exam	____	____
Musculoskeletal	____	____	Lungs	____	____	Pelvic Exam	____	____	Rectal Exam	____	____
Extremities	____	____	Neck	____	____	COMMENTS: _____					

COLLEGE OF HEALTH PROFESSIONS CLINICAL REQUIREMENT (Submit Documentation)

1. **Physical Examination within the past year.**
2. **TWO MMR'S OR POSITIVE RUBEOLA, RUBELLA and MUMPS TITERS**
3. **HEPATITIS B VACCINES: 3 Vaccines or Positive Titer**
4. **VARICELLA/CHICKEN POX: Two Varicella vaccinations or a positive Varicella Titer.**
5. **Current year (season) INFLUENZA VACCINATION (or waiver).**
6. **Tuberculin Testing: Current year negative TB skin test or negative QFT. If history of positive TB skin test or positive QFT, and negative Chest X-Ray, annual symptoms review must be completed. Copy of Documentation Required.**
7. **TDAP Vaccine**

Please attach immunization record and/or serum antibody laboratory results.

Tuberculosis:

PPD Test: **Date placed** _____ **Date read** _____ **Results** _____ **mm**
OR **Read by** _____ **Initials**
Quantiferon: **Date:** _____ **Results** _____ **(attach copy)**

I hereby certify that I have examined the above patient and this is a complete and accurate record of my examination. I hereby state this individual is in good physical health without limitations or restrictions.

Notes: _____

_____ _____
Physician, APRN, PA, DO, MD Signature **Date**

Provider name printed or stamped _____ **Telephone** _____

Address _____