University of California, Irvine
Student Health Center

501 Student Health
Irvine, CA 92697-5200
(949) 824-5301
www.shs.uci.edu

PHYSICAL EXAMINATION RECORD

Name _____ **Date of Birth** _____ **Sex** _____
Last First MI

Allergies _____ **Date of Exam** _____

Regular Medications/Dosage:	Wt _____ Ht _____ BMI _____ T _____ P ____ RR ____ BP _____ /____	Laboratory tests:

V. A. OD OS OU Uncorrected Corrected	**NORMAL**	**ABNORMAL FINDINGS**
VISION SCREEN		
HEARING SCREEN		
HEAD, NECK, THYROID		
CHEST/LUNGS		
HEART		
BREASTS		
ABDOMEN		
GENITAL, HERNIA CHECK		
PAP SMEAR (IF INDICATED)		
SPINE, MUSCULOSKELETAL		
NEUROLOGIC		
MENTAL/PSYCHIATRIC		
OTHER		

HEALTH ASSESSMENT SUMMARY

❑ No significant health concern

❑ Health concern found (Explain below)

❑ Student cleared for participation in _____

❑ Student not cleared for participation in _____ (Explain below)

_____

_____

_____

_____

_____

Form completed by:

Printed Name _____ **Medical Professional Title** _____

Signature _____ **Date** _____ **License #** _____

Address _____ **Phone No.** _____

PATIENT NAME: **MR#:**