UNIVERSITY OF THE PACIFIC

Pacific Health Services

HISTORY AND PHYSICAL (Recommended, not required)

This document consists of a two paged History and Physical. It is to be completed by a Physician, Nurse Practitioner or Physician's Assistant, signed and dated on page 2.

STUDENT'S NAME: _____ **DATE:** _____

DATE OF BIRTH: _____ **GENDER:** _____ **STUDENT ID #:**_____

SCHOOL ADDRESS: _____

PHONE NUMBER: _____ **MAJOR:** _____**GRAD YEAR:** _____

PAST MEDICAL HISTORY:

1. Significant past health problems, major illnesses/injuries, surgeries, hospitalizations: _____
2. Childhood Diseases: _____
3. Medications (Prescribed, Vitamins, Supplements, OTC) within the last 3 months: _____
4. Drug allergies & reactions: _____

FAMILY HISTORY:

1. Parents: _____
2. Siblings: _____

SOCIAL HISTORY:

1. Employment: _____
2. Exercise program: _____
4. Dietary Patterns: _____

SUBSTANCE USE:

Alcohol: _____ Tobacco: _____ Recreational Drugs: _____

REVIEW OF SYSTEMS:

General: _____ **Ears:** _____

Skin: _____ **Nose:** _____

Head: _____ **Throat:** _____

Eyes: _____ **Mouth:**_____

NAME: _____ **ID #:** _____

ROS:
Breasts: _____ **Ob/Gyn:** _____

Resp: _____ **MS:** _____

CV: _____ **Neuro/Psych**: _____

GI: _____ **Heme/Lymph:** _____

GU: _____ **Endo:** _____

Other: _____

PHYSICAL EXAMINATION:

Ht _____ **Wt** _____ **BMI** _____**BP** _____ **Pulse** _____ **Resp** _____ **Temp** _____

Visual Acuity **Right** 20/_____ **Left** 20/_____ **Both** 20/_____ uncorrected corrected

Sexually Active: **Yes**_____ **No**_____ **Number of Children**:____

(Write "N/A" if item does not apply to student)

GENERAL/Mental Status: _____

SKIN: _____ **LUNGS:** _____

HEAD: _____ **CV:** _____

EYES: _____ **ABD:** _____

EARS: _____ **EXT:** _____

NOSE: _____ **NEURO:** _____

THROAT: _____ **GU MALE:** _____

NECK: _____ **LAST PELVIC RESULT:** _____ **DATE:**_____

BREASTS: _____

ASSESSMENT AND PLAN:

1. Health recommendations: _____
2. Please review the student's immunization status, provide the necessary vaccines and/or titers to complete entrance requirements. Please provide documentation of immunizations.
3. Please review the student's TB status, administer the appropriate TB screening and provide appropriate documentation of TB clearance to complete entrance requirements

_____ _____ _____
Signature of Provider/Printed Name **License #** **Date**

_____ _____
Address of Provider (Stamp preferred) **Phone/Fax Numbers**