Respiratory Care Program Physical Examination Form

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Name_____ Date_____

Date of Birth_____ Age_____ Gender _____

Address_____ Phone_____

City_____ State_____ Zip Code_____

Do you now have OR have you ever had:

( ) Yes ( ) No Back, Spinal, or Neck Injury
( ) Yes ( ) No Diabetes
( ) Yes ( ) No Exertional Fainting
( ) Yes ( ) No Eye Injury
( ) Yes ( ) No Heart Attack
( ) Yes ( ) No Heart Problems
( ) Yes ( ) No Hypertension
( ) Yes ( ) No Mental Illness
( ) Yes ( ) No Racing Heart/Skipped or Irregular Beats
( ) Yes ( ) No Seizures
( ) Yes ( ) No Stroke/ Phlebitis

Explain YES answers: _____

_____

_____

Medications: _____

Have you ever experienced back pain that has limited your activities of more than 1 day? ( ) Yes ( ) No Explain YES answer: _____

_____

_____

How many days per week do you exercise 30 minutes or greater? _____

Student Signature _____

Height_____ Weight_____ BP_____/_____ P_____

Vision- Color Vision Test: ( ) Normal ( ) Deficiency Identified

Near:(R) 20/____(L)20/____(OU) 20/____Far:(R) 20/____(L)20/____(OU) 20/____

Contacts or Glasses ( ) Yes ( ) No Wearing for exam ( ) Yes ( )No

Hearing: ( ) Satisfactory with normal speech range ( ) Refer for testing

Corrective Devices ( ) Yes ( ) No Wearing for exam ( ) Yes ( )No

50 Pound Wait Lift: ( ) Independent ( ) With Assistance ( ) Unable to Lift

Manual Dexterity: ( ) Both Hands ( ) Right Hand ( ) Left Hand

( ) Satisfactory ( ) Limited ( ) With Assistance Device

	Normal	*Abnormal/ Comments*
Ear Nose Throat (ENT):		
Cardiopulmonary:		
Abdominal:		
Peripheral Vascular:		
Musculoskeletal: • *Spine* • *Extremities* • *Mobility/Strength*		
Neurological:		
Mental Status:		

( ) Satisfactory Exam: No Restrictions or Limitations
( ) Not Cleared: Needs further rehabilitation, evaluation, or referral

MD Signature_____ Date_____

Print Name_____ Office_____