

# Yale UNIVERSITY HEALTH SERVICES

Due: July 20, 2009

## Health Form and Physical Exam

**Return To:**  
Yale University Health Services  
New Student Forms  
17 Hillhouse Ave.  
P.O. Box 208237  
New Haven, CT 06520-8237

### Yale University affiliation (check one)

- Undergraduate, Class of \_\_\_\_\_  Health Professions \_\_Medical \_\_Nursing \_\_PA  
 Graduate Student, Department or School \_\_\_\_\_

Last Name	First Name	Date of Birth: ____/____/____ Month Day Year	
E-mail	Student Cell Phone	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
Home Address	Parent/Guardian Home Phone	Parent/Guardian Work Phone	
Emergency Contact Name	Relationship	Emergency Contact Phone	

### Physical Examination | To be completed and signed by your healthcare provider

Height	Weight	BMI	Blood Pressure	Pulse
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Allergies to medications? Yes No *(If yes, please list)*

Severe food allergy? Yes No *(If yes, please list)*

Is an EpiPen® prescribed? Yes No Insect allergy? Yes No Environmental allergy? Yes No

If this patient receives allergy immunotherapy please complete the **Student Allergy Medical Treatment Plan** form.

Current or past medical, surgical, or psychiatric condition(s) requiring ongoing care. *Please list and include relevant medical information*

Prescription medication(s) *Please list:*

Vitamins, supplements and over-the-counter medications taken regularly *Please list:*

Questions? E-mail us at [studentmed@yale.edu](mailto:studentmed@yale.edu)

**Yale University Health Services**  
**Health Form and Physical Exam**

<b>Last Name</b>	<b>First Name</b>	<b>Date of Birth:</b> ___/___/___ Month Day Year
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<b>Clinical Evaluation</b>	<b>Normal</b>	<b>Abnormal</b>	<b>Comments</b>
Skin			
Head, ears, eyes, nose, throat, hearing and visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Lungs/Chest			
Breasts			
Heart (supine and standing)			
Abdomen			
Genitalia			
Back/Spine			
Extremities/Musculoskeletal/Femoral Pulses			
Neurologic			
Emotional/Psychological			
Other findings			

Is this student cleared for full physical activity, including participation in intramural and club sports, and able to meet the physical and emotional demands of college life, including studying abroad?

Yes/Unlimited activity and fit for college     
  No/Limited activity     
 Reason: \_\_\_\_\_  
 Recommendations: \_\_\_\_\_  
 \_\_\_\_\_

**I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge.**

<b>Signature of Healthcare Provider</b> <i>(Parent or guardian cannot sign as the healthcare provider)</i>		<b>Date</b>	<b>Phone</b>
<b>Print Name of Healthcare Provider</b>	<b>Address</b>		<b>Fax</b>