

# PHYSICAL EXAMINATION REPORT

COLLEGE OF DUPAGE HEALTH SERVICES  
425 FAWELL BLVD., GLEN ELLYN, ILLINOIS 60137  
630-942-2154 tel / 630-942-2071 fax

Please Print

Name \_\_\_\_\_  
Last First

Allied Health Program \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

**Must be completed by a licensed medical professional**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

**Physical Findings - Must be completed by a Licensed Medical Physician**

Body Systems	Normal	Abnormal, please describe
Cardiovascular		
Eye		
Ear, Nose, Throat		
Conversational Hearing		
Gastrointestinal		
Metabolic-Endocrine		
Musculoskeletal		
Neurological		
Respiratory		
Skin (Exposed areas only)		
Lymph Nodes		

Specify any restrictions regarding student's ability to perform in direct relation to educational expectations, including hospital clinical practice.

\_\_\_\_\_  
\_\_\_\_\_

Is student presently under any medical treatment? If yes, explain,

\_\_\_\_\_  
\_\_\_\_\_

Summary of Findings \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name (Please Print) \_\_\_\_\_ Date of Examination \_\_\_\_\_

Signature of Examiner \_\_\_\_\_

Doctor's Office Stamp – Include Address & Phone

*This physical exam satisfies the requirements of all College of DuPage Allied Health programs and all clinical sites.  
This physical does not replace a comprehensive physical by your family physician.*