St. Charles Community College
Physical Exam

Name_____Age_____Date of Birth_____
Last First Middle

Address_____City_____State_____Zip_____

Health History

Yes	No		Yes	No	
_____	_____	Head or spinal injuries (severe)	_____	_____	Stomach Ulcer
_____	_____	Convulsions (fits, epilepsy)	_____	_____	Rheumatic Fever
_____	_____	Encephalitis (sleeping sickness)	_____	_____	Asthma
_____	_____	Ever confined as a chronic invalid	_____	_____	Kidney Disease
_____	_____	Heart Disease	_____	_____	Suffering from incurable disease
_____	_____	Tuberculosis	_____	_____	Permanent defect as a result of disease/accident
_____	_____	Syphilis			
_____	_____	Gonorrhea	_____	_____	Diabetes

Explain positive answer: _____

Do you have any pre-existing conditions: If so, please explain: _____

PHYSICAL EXAMINATION

General appearance and development: Good_____Fair_____Poor_____Weight_____Height_____

HEAD: (with/without glasses) Eyes: For distance: R20/_____ L20/_____
Evidence of disease or injury: R_____ L_____
Color vision_____Horizontal field of vision: R_____ L_____
Ears: Hearing-20 ft., Right ear _____ Left ear _____
Mouth _____Throat_____
THORAX: Heart_____Lungs _____
If organic disease is present, is it fully compensated:_____
Pulse: Before exercise_____ Two minutes rest after exercise _____
Blood Pressure (sitting): Systolic _____ Diastolic _____
ABDOMEN: Scars_____Abnormal Masses_____ Tenderness_____
Hernia: Yes_____No_____ If so, where_____ Is trust worn_____
GENITO-URINARY: Scars_____ Urethral discharge_____
Does menstruation period incapacitate her from school duties? _____
How many days _____
REFLEXES: Rhomberg_____
Pupillary_____Light R_____ Accommodation R_____ L _____
Knee Jerks: Right normal _____increased_____absent_____
Knee Jerks: Left normal_____ increased_____absent_____
EXTREMITIES: Upper_____ Lower_____ Spine _____

Laboratory Findings (Not required unless indicated by findings in general examination)
Urine: Spec. Gr._____Alb._____ Sugar_____
Blood Serology_____Chest X-Ray_____

Date of Last Tetanus Shot_____

DOCTOR'S CERTIFICATE

This is to certify that I have this day examined this student and find him/her:
_____ Qualified for athletics
_____ Qualified for all modified physical activity for reasons explained:_____

Signature of Examining Doctor_____Date_____

Address_____City_____State_____Zip_____

Phone_____