

# PHYSICAL EXAMINATION

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING:  
**HEALTH.URI.EDU**



DR. PAULINE B. WOOD HEALTH SERVICES

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**\* A physical exam is NOT REQUIRED, however, you may submit a physical exam report from your provider (or use this form) if your last physical exam was within 18 months.**

**STUDENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
(Please print) Last Name First Name MI

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_

**PHYSICAL EXAM:** ☐ NORMAL ☐ ABNORMAL

**IDENTIFY ABNORMALS:**

**IMPRESSION** (diagnoses, recommendations, restrictions).

Please note any health problem, chronic health condition or disability that may affect behavior or health of the student while at college.

<b>ALLERGIES</b> (Please list <b>ALL</b> allergies to medications, foods and other miscellaneous items)	
<b>MEDICATION ALLERGIES:</b>	
<b>FOOD ALLERGIES:</b>	
<b>OTHER ALLERGIES:</b>	<input type="checkbox"/> BEES <input type="checkbox"/> LATEX <input type="checkbox"/> NUTS <input type="checkbox"/> SEASONAL / POLLEN

<b>MEDICATIONS</b> (Include prescriptions, over-the-counter, and herbal)			
NAME	DOSE	FREQUENCY	RELATED DIAGNOSIS

**PROVIDER SIGNATURE:** \_\_\_\_\_ **DATE OF EXAMINATION:** \_\_\_\_\_

**PROVIDER NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_