

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.

ALLERGIES (Please list ALL allergies to medications, foods and other miscellaneous items)	
MEDICATION ALLERGIES:	_____

FOOD ALLERGIES:	_____

OTHER ALLERGIES:	<input type="checkbox"/> BEES <input type="checkbox"/> LATEX <input type="checkbox"/> NUTS <input type="checkbox"/> SEASONAL / POLLEN

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

PROVIDER SIGNATURE: _____ DATE OF EXAMINATION: _____

PROVIDER NAME: _____ PHONE: _____ FAX: _____

ADDRESS: _____