Cayuga HEALTH | ITHACA COLLEGE Student Health Services

PHYSICAL EXAM

To be completed by your physician or health care professional.

Please complete the form below or send a copy of a complete physical exam done within the past year.

Patient Name: _____ DOB: _____

Past Medical/Surgical History: _____

_____

_____

Medications (please list any medications the patient is currently taking):

1) _____ **4)** _____
2) _____ **5)** _____
3) _____ **6)** _____

Allergies (please list any known allergies or adverse reactions):

1) _____ **3)** _____
2) _____ **4)** _____

DATE OF PHYSICAL EXAM (MM/DD/YYYY): _____

Height: _____ Weight: _____ BP: _____ Pulse: _____

	Normal	Abnormal	Comments
Skin	☐	☐	
HEENT	☐	☐	
Neck/Thyroid	☐	☐	
Lymph Nodes	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Musculoskeletal	☐	☐	
Other			

List all current medical and mental health issues:
1) _____
2) _____
3) _____

Recommendations for continuing care:
1) _____
2) _____
3) _____

Please attach or forward any medical records that may be needed in order to provide appropriate care to this student while they are at college. ***Mail records to: Cayuga Health at Ithaca College, 953 Danby Road., Ithaca NY 14850 ATTN: Medical Director OR fax to: (607)-274-1844.*** *If the student will need continuing care for a medical issue, please instruct them to contact the Health Center for an appointment. We cannot automatically assume responsibility for a student's care without their willing participation.*

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Certifying Signature: _____ Date: _____
Name of Physician or Healthcare Facility: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____