WICHITA STATE UNIVERSITY
STUDENT HEALTH SERVICES
1845 Fairmount Street
Wichita, KS 67260-0092
Ph. 316-978-3620 Fax: 316-978-3517

PHYSICAL EXAMINATION FORM

Circle Program and Year:				
1st Year	2nd Year			
Dental Hygiene	Nursing	Grad Nursing	PA	PT
Med.Tech.	CO-OP	Student Teaching	________	

PERSONAL AND ANY FAMILY MEDICAL HISTORY My WSU ID #____________________

Name:____
Last First Middle

Date of Birth:______________________ Telephone: (h)______________ (c)______________
Month/ Day /Year

Address:____
Number Street Apt # City State Zip Code

Emergency Contact:____
Name Address Phone #

Family Physician:____
Name Address Phone #

Allergy to drugs/food/plants, other:________________________________
____

		RELATION/SELF	PROVIDER CONCERNS	BEHAVIORAL HEALTH:	
	Asthma			Tobacco use	Y/N
	Cancer			Smoke?	
	Diabetes			Chew?	
	Elevated blood pressure/stroke			Other__________	
	Heart disease			If yes, # per day?	
	Other:			Alcohol Use?	
	Auto Immune Disorder			If yes, # drinks/week	
	Blood Clots			Other Drug Use?	
	Depression			What type__________	
	Epilepsy or Seizures			Do you exercise?	
	Gall Bladder Disease			Get 8 hrs sleep/day?	
	Hepatitis /Liver Disease			Handle stress well?	
	High Cholesterol			Use Seat Belts?	
	Stroke			Text while Driving?	
	Thyroid Disease				

Chronic or Serious illnesses or hospitalizations (list):	
Surgeries or injuries (broken bones, head injury, etc.:	
Current medications (including any birth control):	
History of physical/emotional/sexual abuse:	

SEXUAL HEALTH HISTORY	Yes	No
I have not had sex		
I have had vaginal sex		
I have had anal sex		
I have had oral sex		
Female partners		
Male partners		
Have you received the Gardasil vaccine?		

Have you ever had: (please circle):	Chlamydia Gonorrhea Syphilis HIV Herpes HPV

Age at first intercourse	
Total number of partners	
Number of partners currently	
Length of current relationship	
Do you self exam ____Breast____Testicular	

FEMALES ONLY:

Number of pregnancies___births___living children____other___
Condom use: ___ Always___Most of the time___Sometimes___Never
Contraception you currently use:
___Abstinence___None___Patch___Implanon___IUD___Pill___DEPO
___Pulling Out/Withdrawal___Condoms___Nuvaring
Any problems with contraception?__________________________

MENSTRUAL HISTORY:

First day of your last period? (mm-dd-yyyy)_____-__________-___
Age at your first menstrual period?__________
How many days do your periods last?________
Are your periods regular? (21-38 days apart)__or irregular______
Period problems?________________________________

PAP HISTORY (mark any you have ever had):

____Pap Smear: If so, When______________Where__________
____Abnormal Pap: If so, When___________Where__________

0020B-99 rev 08-01 03/07, 06/09, 04/10, 08/10, 12/12, 05/13, 07/13

Physical Examination **Student's Name**______________________________

Blood Pressure________________Pulse__________Weight_______BMI__________Height______________LMP__________

Normal	Abnormal	Check appropriately and describe abnormalities.	Provider Comments:
		Head, Scalp and Face	
		Eyes Date of last exam	
		Right: Left: with glasses without glasses	
		Ears	
		Nose	
		Mouth and Throat	
		Teeth Last Exam:	
		Thyroid	
		Lungs	
		Heart	
		Breasts	
		Abdomen	
		Musculo-skeletal	
		Neurological	
		Skin	
		Femoral and pedal pulses	
		Pelvic Exam:	
		External Genitalia and BUS	
		Vagina	
		Cervix	
		Uterus AF M RF	
		Adnexa	
		Recto-Vag	

Notes:____

____

Labwork:_____Pap Smear_____GC_____Chlamydia_____UA_____CBC_______Mumps Titer___________Rubella Titer _________Rubeola Titer ___________Varicella Titer

Other:____

COLLEGE OF HEALTH PROFESSIONS CLINICAL REQUIREMENTS:
COPY OF DOCUMENTATION NECESSARY FOR EACH REQUIREMENT

1. **Physical Examination within the past year.**
2. **TWO MMR'S OR POSITIVE RUBEOLA, RUBELLA and MUMPS TITERS**
3. **HEPATITIS B VACCINES: 3 Vaccines or Positive Titer (Titer required for PA dept.)**
4. **VARICELLA/CHICKEN POX: Two Varicella vaccinations or a positive Varicella Titer.**
5. **Current year (season) INFLUENZA VACCINATION (or waiver).**
6. **Tuberculin Testing: Current year negative TB skin test or negative QFT. If history of positive TB skin test or positive QFT, and negative Chest X-Ray, annual symptoms review must be completed. Copy of Documentation Required.**
7. **TDAP Vaccine**

Influenza Vaccine(date -vaccine or waiver) ____________________Date of Td/Tdap vaccine:__________________

Tuberculin Screening: Type of test:_______________Date given:________________Results:_____________mm____

(must be within last 12 months) Date read:_________________________By whom:___________________________

Quantiferon Gold Screening: Date:________________________Results:_________________________________

Chest X-Ray: Date:________________Results:__________________Signs/Symptoms review:___________________

Summary of student's health:

a. Physical:____Date of Exam__________________

b. Recommendations for follow up:____

Signature of Examiner (MD, DO, APRN, PA)____

Examined by (**please print**):____Telephone Number______________

Physician Signature after review:____