Unity Nursing Institute

Physical Evaluation

(Note: This form is to be filled out by the student's MD, NP, or PA.)

Name of student: _____ Date of birth: _____

Sex _____ B/P_____ Pulse _____ Respiration _____
Temperature_____ Weight ____

Medicines and Allergies:

Please list all the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

_____

_____

_____

Do you have any allergies? ☐Yes ☐No

If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Please list any physical problem:		
Please list any mental health issue:		
	Yes	No
1. Do you regularly use a brace, assistive device, or prosthetic?		
2. Do you use any special braces or assistive device for sports?		
3. Do you have hearing loss? Do you use a hearing aid?		
4. Do you have a visual impairment?		
5. Have you had autonomic dysreflexia?		

6. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
7. Do you have muscle spasticity?		
8. Do you have frequent seizures that cannot be controlled by medication?		

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____

Please list any recommendation if applicable: _____

_____

_____

Date of exam _____

Medically Cleared: ☐Yes ☐ No

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