COLUMBIA STATE COMMUNITY COLLEGE
EST 1966

Nursing Physical Exam Form
Health Sciences & Nursing
www.columbiastate.edu
Phone: (931) 540-2849 Fax: (931) 560-4103
healthrecords@columbiastate.edu

Physical Exam Form Page 1 of 2 **NOTE: Attach all Lab and Radiology reports to this form.**

Date of Physical Exam:_____ Name of Student: _____

Home Phone:_____ Cell Phone: _____

Date of Birth_____ SS#_____ Sex M__ F___ Age _____

Height_____ Weight_____ BP_____ Pulse_____ Temperature _____

Urinalysis: Protein_____ Leukocytes _____

Glucose_____ Blood_____ Bilirubin _____

Hematocrit:_____ CBC (optional) _____

Eyes_____ Visual Acuity R_____ L _____
Color Blindness Y_____ N _____

Ears_____ Hearing R_____ L_____

Nose_____ Oropharynx _____

General condition of teeth (caries, dentures, braces, implants) _____

Skin_____ Breasts _____
Musculo-skeletal system (joint instability, inflammatory conditions, surgical repairs): ____
Spine: _____

Cardiovascular_____ Respiratory _____

Abdomen (pain, scars, masses, hernia) _____

Genito-urinary system_____ Hemorrhoids _____
Varicosities _____

Is this student in good physical condition?_____ Reasons he/she is not: _____

_____

Physician's recommendations for further testing or comments: _

_____

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Physical Exam Form—Page 2 of 2 **NOTE: Attach all Lab and Radiology reports to this form.**

Re-Enter Name of Student: _____

Date of 2-step T.B. skin test **(required)**: Date Administered:_____Date Read:_____Result: _____

Date Administered:_____Date Read:_____Result: _____

NOTE: If T.B. skin test is **positive**; you must submit a chest X-ray report. Date:_____Results: _____

Date of Mumps titer/IGG **(required)**_____**Attach lab report for result:** _____

Date of Rubella Titer/IGG **(required)**_____**Attach lab report for result:** _____

Date of Rubeola Titer/IGG **(required)**_____**Attach lab report for result:** _____
NOTE: If no immunity, MMR immunization is required. Date of MMR booster: _____
You must repeat titer(s) two months following immunization. **Attach lab report for result.**

Date of Varicella Zoster titer/IGG **(required)**_____**Attach lab report for result:** _____
If *NOT* immune: Date of Varicella Zoster immunization #1:_____#2: _____

Have you had chicken pox? YES_____NO/NOT SURE _____

Date of Tetanus/Diphtheria/Pertussis (Tdap) Booster **(required)**:_____***You must have a booster if your vaccination is over 10 years old***

Date of Seasonal Influenza Immunization**:** _____
(MANDATORY: Fall nursing students must submit no later than September 24th—spring nursing students must submit with all other healthcare paperwork upon entry into the nursing program)

Date of Hepatitis B series (received): #1_____#2_____#3 _____
Date of Hepatitis B Surface Antibody (Surface Ab) titer ***(required 60 days after Hepatitis B series is administered and/or must have if you have ever had a Hepatitis B series)*** **(Attach Hepatitis B titer lab report).** Results: _____

_____ _____
Healthcare Provider's Signature Physician's Address

_____ _____
Print or type Healthcare Provider's Name Date of Examination